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HEALTH CARE REFORMS IN ESTONIA AND HUNGARY: LESSONS FOR UKRAINE

Countries of Central and Eastern Europe can be characterised by universal access health care systems. The specific of the region is that historical and continuing underfunding has resulted in poor infrastructure and lack of staff incentives. Almost all the countries of the region have started health care reforms but we can see dramatic differences in the achievements as some of them have succeeded enough to enter the EU while others are stuck on the way. This paper presents the experience of the health care reforms in two countries of Eastern Europe, reflects changes in structure and financing of the systems.

Health care is an issue of substantial concern to Ukrainians. Many agree that the current system is in dire need of reform, yet it is unclear exactly what form the changes should take. This paper will examine the paths that Estonia and Hungary have taken in the health care reform process. It will give a brief overview of the processes these two Central European Countries have employed and then attempt to extrapolate some points to keep in mind when reforming Ukraine's system of health care.

Sakari Karjalainen, secretary general of the Research Council for Health (Academy of Finland) provides three criteria for, evaluating health systems in the statement: "The main, and competing, challenges [in health care reform] are to improve the quality of health care, maintain and improve equity, and increase efficiency" [1]. This paper will thus use these three qualities as premises to examine the post-reform health care systems first in Estonia and then in Hungary.

Background of Estonia

Estonia borders Latvia and Russia. It became a parliamentary republic in 1991 when the USSR collapsed and it gained its independence. In 2004 Estonia joined both NATO and the EU. Estonia currently has a population of 1.3 million (July 2005 est.) [2]. Economically Estonia has made significant improvements since Soviet times by attracting foreign investments and tourism, and has a growing middle class.

Similar to other formerly socialist countries, Estonia had a centralized, hospital based, health care system known as the Semashko model up until the early 1990s. However, after independence, health reform became one of Estonia's top priorities. The reforms have focused on two main areas: transforming from a centralized to a decentralized system, and from a model fully funded by government budget to a health insurance model. *Medicover,* an organization specializing in private health care to companies organizations and individuals, states in **a** corporate analysis of the Estonian health system that the three reasons Estonia chose these areas of focus are because there was lack of a relationship between health care expenditure and national economy; an excess of hospitals and specialized doctors in the health care system; and an overcapacity in secondary and tertiary care but **a** severe lack of primary health care for Estonians [3].

Outline of Current Health Care System in Estonia

The Estonian health care system began its reform by implementing the "family doctor" system in 1997 with a special emphasis on primary health care. All persons insured with the Estonian Health Insurance Fund have a family practitioner, although even a person not residing in Estonia may also visit a family practitioner. *Medicover* notes that a person needs a referral from the family practitioner to visit a medical specialist unless the specialist is a psychiatrist, gynaecologist, dermatovenerologist, ophthalmologist, dentist, pulmonologist (for tuberculosis treatment), infection specialist (for HIV/AIDS treatment), surgeon or orthopaedist (for traumatology) [4]. In any case each family doctor has a pool of patients that come for initial diagnosis and referrals (if necessary). In many places the family doctors have their consultation rooms in the out-patient clinic inside or near the hospital and specialists work both in the hospital with in-patients and in the policlinic with out-patients.

A mail survey in 2002 conducted by health executives found that 27.8% and 62.7% of a representative sample of the population deemed the post-

reform quality of health care in Estonia to be respectively good or satisfactory [5].

In its analysis, *Medicare* found the financing of Estonia's health care system to be quite balanced and the social health insurance fund well maintained. The Estonian Health Insurance Fund is the only organization in Estonia that handles compulsory health insurance, and its main purpose is to cover the costs of health services for insured persons, prevent and cure diseases, finance medicinal and technological products and other benefits. Thus the health care system can be said to be characterized by social insurance which relies on the principle of solidarity, *Medicare* states that "the Health Insurance Fund (EHIF) covers the cost of health services required by the person in case of illness regardless of the amount of social tax paid for the person concerned. The Fund uses the social tax paid for the working population also for covering the cost of health services provided to persons who have no income with regard to work activities. The employers are required by the law to pay social tax for all persons employed, whereby the rate of this tax is 33 % of the taxable amount, and of which 20 % is allocated for pension insurance and 13 % for health insurance".

Medicover goes on to cite that of the total expenses for health care in Estonia, currently 60% goes to hospital care, 20% to primary care/family doctors and 20% to specialized care according to special programs.

The Estonian Health Insurance Fund health insurance is organized by four local departments, and currently the biggest obstacle to efficiency is the growing lack of medical personnel. Since joining the EU, Estonian doctors and nurses began migrating to other EU countries in search of higher paying positions. However, as of 1 January 2005 an agreement between the Estonian government and Estonian Hospitals Association was enforced which raised and established minimum wages for doctors and nurses for the current and next year [6].

So, after providing this reform in Estonia the results could be seen as following:

- decetralization to county level and devolution of power to the local governments;
- the new Ministry of Social Affairs was established (Ministry of Health, Social Welfare and Labour were merged into one). This ministry is responsible for health and social services, policy development, planning and data collection;
- the Estonian Sick Fund Law was established;
- the number of sickness funds was decreased to a single fund with 3-5 regional funds;
- health care (primary, secondary care and control of public health needs) was organized by the municipalities [7].

Background of Hungary

Hungary is landlocked in a strategic location between Western Europe and the Balkan Peninsula as well as between Ukraine and Mediterranean basin. Hungary is a parliamentary democracy and has a population of 10 million people (July 2005 est.). It held its first multiparty elections in 1990, joined NATO in 1999 and the EU in 2004 [8]. Economically Hungary also has a growing middle class, however ongoing unresolved political issues relating to minority rights are coloring the political and economic landscape.

Hungary has a long established history of organized health care using industrially organized insurance health funds based on the German Bismarck model established in the 19 century. After the Second World War, and the establishment of a communist government, the Semashko model of centralized health care was introduced with both provision and financing being centralized as well as government owned and controlled. The introduction of this universal health care system led to initial large improvements in public health, however beginning in the 1970's the health care status of the Hungarian population started to fall behind Western European levels. All of the problems associated with the Semashko Soviet health care model manifested themselves in the Hungarian health care system. The legacy of this model is still holding back the current health care system and many of the problems have not yet been solved despite a new political willingness to address these issues [9].

So, health care reform in Hungary started in 1980s because: populations' health status was deteriorating; health care costs were high because of hospital - central services; health care professionals had low income levels; and consumers were not satisfied with the lack of choice and the poor standard of care. In general the existing system was considered to be inefficient and ineffective.

The health care reform which started in 1987 and continued in 1990-1994 had ideas of: decentralization; introduction of perfomance-based methods of paying providers; public health reform;and giving priority to primary care. At first, reform was rather fast-going, but after 1991 it slowed because of financial crisis in the country and defining other priorities besides health care.

Outline of Current Health Care System in Hungary

The current health care system in Hungary of-

fers free coverage for residents of Hungary, however, the quality of the care varies greatly depending on whether it is privately owned or state funded. The reformed system consists of three levels: national (Ministry of Health, other relevant ministries and other bodies which were responsible for regulation, policy and planning); sub-national (municipal governments, local offices of the public health service which were responsible for management of health care facilities, monitoring of public health); and private providers (this sector is concerned on service provision).

As *Medicover*'s corporate analysis of the health care system in Hungary states, "the Hungarian state health insurance system is based on the principle of a universal service, free at the point of delivery, and the right to health care is established in the constitution. Private providers have been encouraged and developed in the primary and some of the secondary sectors, and almost all general practitioner practices are privately run and funded on a capitation basis by the health insurance fund, however none of these were privatized and contracted under an overall, well structured reform initiative, but more based on unclear decision processes. Thus, the provision of inpatient care is still state owned and controlled via local government or the Ministry of Health."

Attempts at changing this system are "politically controversial despite the fact that...[two pilot privatized] hospitals are well managed and have improved quality of care, access, client satisfaction and financial performance. Those institutions still run by the state or local municipalities lead a precarious life. With a shortage of funding to continue to maintain the infrastructure many of these institutions running into funding problems and incur large debt burdens with the consequence of having high management turnover... Despite many highly visible government programs, real preventive care programs are not yet established."

Additionally, because general practitioners receive salaries on a capitation basis (as opposed to health outcome or real performance), they often take little interest in results or quality of their work as their income remains the same whether they provide effective care or not.

The Hungarian health care system operates on the basis of dual financing. Major investments such as construction, maintenance and equipment purchasing are financed by the regional authority or co-financed by the Ministry of Health. All expenditures of the daily operations, including salaries of health care professionals, are financed by the Health Insurance Fund. However insurance rates are often too low to cover the real costs of providing the services. Thus the lack of adequate funding has led to the continuation of informal payments (gratuities, bribes) and use of public facilities for private practice businesses to enable health care staff to supplement their incomes.

In-patient care is primarily funded by a Diagnostics Related Group (DRG) system of reimbursement imported from Germany in early 1990's, though the available budget and minimal resources often keep many institutions in permanent bankruptcy. (DRGs are the best known classification system used in a case-mix funding model. The classification system groups inpatient stays into clinically meaningful categories of similar levels of complexity that consume similar amounts of resources [10]). The result is that hospitals try to add as many diagnoses, referrals and treatments as possible to get maximize funding from the health insurance fund. This problem is compounded by the fact that the health care contributions payable by employers and employees are a large burden on salaries and have led to numerous and widespread schemes to avoid the high level of taxation, which in turn contributes to the cycle and further reduces the tax base for health care provision. *Medicover* also notes that "despite attempts to reduce reliance on informal [out of pocket] payments in the health care system, these are as much a part of receiving care today as they were under the Communist system" [11].

Basically the current method of financing is unstable and unsustainable as a central health care fund is not a viable way of improving the health care system unless it is coupled with an additional voluntary and non-overburdening method of funding alongside methods of enforcement and accountability. Thus, although the funding reforms have led to some improvements in health care, particularly in the primary care sector, the health care experience for all too many of the Hungarian public remains a disappointing one.

The current health care system is very inefficient due to a number of interrelated factors explored above. The political will to tackle the health care reform agenda returns from time to time along with recognition that further systematic change is required. However, the slow progress in modernizing the health care system is reflected in the low efficiency of hospitals, excessive recourse to inpatient care and heavy prescription of drugs by doctors [12]. More responsibility and accountability needs to be introduced into the health care system as well as incentives for increasing efficiency and maximizing available resources.

Up to the year 2000 health care professionals could say about the results of these political changes. They were:

- establishing the Medical Officer Service;
- the state and local governments divided responsibilities (state was responsible for specialist services and some other kinds of hospitals, as for primary care surgeries, outpatient clinics and hospitals - local government was responsible for maintenance and investment of them);
- the accent in health care was made on health promotion and disease prevention. This helped to strenghten primary health care [13].

Lessons Learned from Estonia and Hungary

Both Estonia and Hungary show that a decentralization of the health care system produces better results in terms of quality, equity and efficiency. Overly centralized systems, like the ones formerly found in Estonia and Hungary and still found in Ukraine, that are still government-owned and/or operated often lead to poor quality service and treatment because of the low motivation base due to lack of resources, incentives and accountability on the side of health care staff and managers.

As Estonia's experience shows, a shortage of general practitioners or family doctors is another factor in substandard quality of health care. An overly specialized pool of health care professionals causes a lack of personalized approach to medicine and can either cause patients to feel unnecessarily uneasy about seeking treatment, or doctors to not wish to treat patients outside of their specialization. This in turn contributes to a lack of universal accessibility to health care. Increasing the base of family doctors ideally helps establish the basis for a trust relationship with patients, thus allowing patients to feel more comfortable about seeking treatment while also increasing the degree of decentralized primary health care.

However, this decentralized system of primary health care referring patients to specialists on an as needed basis can only work efficiently when corruption is rooted out of the health care system and the overall economic situation is stable or beginning to become prosperous (as in Estonia's case). As Hungary's experience shows, centralized systems with fixed staff wages regardless of skill or efficiency coupled with limited resources are prone to encourage out of pocket payments, while private family practices and hospitals are under more pressure to remain transparent in order to attract more patients and develop a sound and attractive reputation.

Ultimately, three things are needed to decrease corruption: first, public opinion needs to be squarely against it rather than condoning it as is currently the case. Secondly, the court system must function independently in order to ensure that those corruption cases brought to them are solved promptly and justly according to the law. Thirdly, the salaries of health care professionals need to be raised substantially so that they will not feel compelled to supplement their meager incomes illegitimately. As Estonia's experience showed, this requires the government to be willing to take additional methods to legitimately increase the wages of health care professionals. This in turn depends on having political will and a political system that is both accountable to its citizens and takes responsibility for its failures (as well as successes). The good news is Ukraine's citizens are extremely concerned about the predominance of corruption currently in Ukraine: 73 percent of Ukrainians thought it was a "very important problem", and 19,3 thought it was important. Much fewer citizens indicated that it was of little importance (3.1%) or not important at all (0,6%) [14].

Conclusion

Although the experiences of Estonia and Hungary are very different from each other, Ukraine can learn from both. Estonia shows how systematic de-centralization, a unified (non-corrupt) approach to alternative methods of financing through insurance coupled with ongoing modification of reforms and norms (i.e. through the recent raising of health care professionals' salaries and the support of the family doctor system) increases the quality of health care in terms of client satisfaction, stability of the health care's financial base as well as the overall efficiency of the system. Hungary on the other hand serves as an example of an attempt to combine centralization with partial privatization, in which the health system remained free of charge at point of delivery and yet also employed a social insurance model of health care to help cover salary costs and other incidentals. Which unfortunately has failed to lead to client satisfaction, organizational efficiency or financial stability of the health care system. Corruption remains widespread and there is an overall sense of confusion and frustration with the reform process. Ukraine would do well to take Hungary's experience into account as many local political parties continue to advocate for a "free" health care system that operates according to market values, or offers higher social benefits coupled with lower social taxes. On a bright note however, Hungary has recently undergone significant politi-

cal changes and there is currently stated political will to make changes to their decrepit, inefficient health care system based on public input and expert recommendations. As the saying goes: Where there is a will there is a way. With sufficient will, Ukraine too can find a way to combine the successes and failures ofother countries into a locally tailored program of reform for the current health care system.

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Луа Потьє

РЕФОРМИ СИСТЕМИ ОХОРОНИ ЗДОРОВ'Я В ЕСТОНІЇ ТА УГОРЩИНІ: УРОКИ ДЛЯ УКРАЇНИ

Країнам Центральної та Східної Європи притаманні універсальні системи охорони здоров 'я. Специфікою цього регіону є хронічне недофінансування цих систем, що спричинило погану інфраструктуру та брак мотивації персоналу. Практично в усіх країнах регіону розпочались реформи охорони здоров'я, проте їх наслідки зовсім різні, оскільки одні країни були успішними й стали членами ЄС, тоді як інші - не просуваються на цьому шляху. У статті розглянуто реформи охорони здоров 'я у двох східноєвропейських країнах, проаналізовано зміни в структурі та принципах фінансування систем охорони здоров 'я.