Estonian Health Care System: Accomplishments and Challenges

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Abstract

In Estonia, everyone has a constitutional right to health. After regaining independence, the country has executed thorough and successful healthcare reforms. The changes are especially noticeable at the primary level of healthcare. Using the most common models it is investigated how Estonia's healthcare system fits into international classifications and what models best describe the healthcare system before and after reforms. It is shown that the Bismarck model, which is chosen as a prototype for the health care system in Estonia suits well in the case of the Estonian society, better than the other models would. It corresponds well to ethical and economic reality of Estonia.

Keywords: Estonia, health care system, reform, sustainability

Introduction

Convening to review first half year report, Estonia's Health Insurance Fund (HIF) is facing a budget deficit of €33m. The hole will be filled from the approximately €114m reserves of HIF but if the system continues, the future is bleak as the fund is predicted to run out of the money in 2020. At the same time the budget strategy approved at end of April predicts that in 2016 HIF ought to show surplus of €0.8m and in the red by €1.3m in 2017 (Värk 2016). There is no doubt that this situation needs to be improved. Due to this severe situation essential proposals appear to change the funding scheme of the health care system in Estonia. Different proposals have made with the aim of improving the financial coverage of the healthcare activities, but the relevance of the applied overall model has not been under discussion at all. It seems to be the most right time to make clear whether the organizational model needs to be changed or the amount of funding increased, or both at the same time. Politicians need to have a framework that they are able to understand and to explain to others in simple terms if they are to make decisions concerning healthcare (Värk 2016). Any change in health care policy is difficult. Special interests pose a continued obstacle

to change. Pragmatism is very important in both legislation and implementation (Obama 2016).

Health care system reforms in Estonia

The breakup of the Soviet Union led to radical reforms in the Estonian health care system similarly to other transition countries in Eastern and Central Europe. New financing schemes were introduced and new models of primary health care were developed. Modern methods of organization and care delivery were implemented to improve the quality of care and health system efficiency. Systematic interventions combined legal, structural, organizational and financial reforms. Although health care reforms in most post-Soviet countries remain uneven and fragmented, Estonia is the first country to implement a comprehensive change in its health care system as a whole and have fully scaled-up reforms in the primary care sector by institutionalizing family practice.

A small number of studies have been conducted to analyse the gate-keeping role of family physicians and define continuing education needs as well as prospects of family practitioners in Estonia (Kalda et al. 2003, Põlluste et al.2004, Tõemets 2008). There is no academic research available employing holistic approach of the Estonian health system reform experience based on a theoretical framework. Health care system classifications help to define the transition of the Estonian health system from one model to another and to explain the consequences of this move. The absence of such study makes it difficult to evaluate the rationality of the main features of the existing health care system, tackle arising problems and make competent suggestions for further developments.

The significance of the present work is in the thorough analysis of the health care system model used in Estonia, which reveals and helps to address its weaknesses and plan on appropriate development for system improvement. Spending on health care takes up a big part of the public budget and requires large investments in sophisticated infrastructure as well as well-trained human resources. Analysis of the health care services organization provides a useful tool to optimize health financing. It is always an appropriate time for this, but especially after the major makeover of the health care system or before embarking on further system changes.

Theoretical framework is applied to analyse health care system changes in Estonia and how the health sector was affected by political decisions. The aim of this study is to find out what impact the implementation of a new health care system model has had on health care system organization and development in Estonia.

Most significantly and widely used health care system classifications or taxonomies are taken as a basis for the model. Well-known classifications

starting with those proposed in the 70s and finishing with the most recently developed classifications are introduced. These include Soviet medicine, classification by economic formation, OECD or liberal-democratic nations classification and the further development of it being ideal-types or models taxonomy (Docteur and Oxley 2004). Based on the review of a variety of important taxonomies, the most appropriate one for the Estonian case – the OECD ideal-types classification from 1987 – is chosen. This classifies healthcare systems by financing source, healthcare services and infrastructure ownership (OECD 1987). It is characterized by the researchers as simple and yet taking into account the most critical dimensions of any health system, well-known and so widely used that it already became a standard classification of the health care systems (Wendt et al. 2009, 74). The defining characteristics of each health care system model and the most important key players are presented.

The OECD classification can differentiate three models: national health care service *aka* the Beveridge model, social insurance *aka* the Bismarck model and private insurance *aka* the modified market model (OECD 1987). Citizens' access to health care is arranged according to these models. In countries with the Bismarck model it is achieved using the participation of employers and employees. In the Beveridge model, all citizens have the right to healthcare and it is funded using general taxation. In the market model, healthcare services are determined by agreements with private insurance companies. Most countries use a mix of these models (Moran 2000, 141).

How a country or society picks a system depends on many factors. Countries in Europe and America approach the question with different understandings of social ethics, which depend on their respective cultures, histories and basis of distributing national income.

First of all, most European countries organized their health care systems from an ethical standpoint of redistributing wealth, which determined the systems' structure. In those countries wealth is purely thought of as social capital and as such the health care system is developed to give everyone more or less the same services. In systems based on an ethics of social solidarity, nearly all citizens can receive health care services on the same basis. However, in the USA, health is seen as everyone's private capital, the risk of damage to which each person generally must reduce by themselves.

Second, the world's healthcare systems can be differentiated by ownership and financing source. Most of Europe's systems use social health insurance. From a social ethics perspective, the main principles of the USA's and Europe's health care systems are opposites (WHO 2008).

Soviet Estonia, like the rest of the Soviet Union, had the Semashko healthcare system, which was funded directly by the national budget and lead by the government's central planning. 3-4% of the national budget was spent on healthcare. The healthcare system was highly centralized, bureaucratic and standardized (Barr and Field 1996, 307-308). The Soviet Union declared that everyone had a right to health and healthcare. This meant free healthcare services for the whole population.

Healthcare workers had the status of civil servant and the government paid their incomes, which were determined centrally (Koppel et al. 2008). Healthcare services were free for the patients, but their actual cost wasn't taken into account, because there was no systemic overview of the services' cost (Lember 2002, 44). Primary healthcare level was not carrying out the coordinating function (Atun et al. 2006, 80).

The roles and relations of key players had to change in the new system. The first stage of health care reform included the introduction of a solidarity-based insurance system predominantly financed by the employees' mandatory contributions, which are mediated by the independent public entity – a sickness fund. The next step consists of institutionalizing a strong family medicine-centred primary care system.

Estonia was one of the first Eastern European countries to begin healthcare reforms (Lember 2002, 48). When the Soviet Union dissolved, Estonia was at a crossroad and had to pick a direction for its healthcare reforms. There was a great desire for change and to move away from a centralized government and toward a capitalist market. Due to the advice of outside experts, the decision was made in favour of social health insurance. The WHO's and World Bank's consultants recommended design of the new healthcare system to Estonia that essentially matched the Bismarck model (Atun et al. 2006, 89, Koppel et al. 2008, 181).

Comparing theoretical models and actual systems helps discover where ideal systems diverge from reality. This approach is called empirical analysis (Wendt et al. 2009, 72). By comparing the features of different models from the OECD classification of health care systems to the specifics of an Estonian health care system, it can be then analysed which model the Estonian health system corresponded to before and after the reforms. The health care system in Estonia corresponds to the defining features of the Bismarck model of the OECD classification. The health care system arrangements in Estonia are typical for this model.

It can be concluded that the Bismarck model, which is chosen as a prototype for the health care system in Estonia suits well in the case of the Estonian society, better than the other models would. It corresponds well to ethical and economic reality of Estonia.

One of the reasons for creating health insurance was the need to provide a reliable source of income for the healthcare system. The distrust of the government that had formed in Soviet Estonia resulted in a desire to fund health care outside of the government's budget. Creating health insurance made it possible to actually leave the old system (Rechel and McKee 2009).

There was a strong need to connect health insurance to the labour market, so people would be interested in working officially and paying taxes. The tax rate of health insurance was set to 13% of each employee's income and was to be paid by their employer. The new health insurance was compulsory with no exceptions. The insurance covered almost every resident of Estonia (Koppel et al. 2008, 181, Lai et al 2013).

There are both strengths and weaknesses of the Bismarck model as they apply to the Estonian case, as well as problems caused by socialist medicine inheritance and issues specific to the transitional society. An important aspect of the reform is the separation of a healthcare service's planner, buyer and provider. Before, the government had all three roles, but after the reform, the sickness fund was the buyer and medical institutions and their personnel were the providers. Strategical planning was left to the Social ministry (Atun et al. 2006, 83). Separating the roles made the negotiation process more transparent, which ensured more efficient use of resources. The main values and goals which directed the healthcare system's development were efficiency, transparency, professional responsibility for the quality of healthcare and choices (although limited) for users of healthcare services. The main values of health insurance were solidarity, limited cost and equal services for all insured individuals regardless of where they live. The sickness fund's goals were set based on these values (Jesse 2008, 8).

Several studies point out that Estonian health care reforms are the success stories by themselves and in the regional context of Central and Eastern Europe (Rurik ja Kalabay 2009, Liseckiene 2007). Factors that led to their success were the following: perfect timing, strong political will, public dissatisfaction with the Soviet health care system and support to the changes, passionate leadership of doctors and the academic community (medical educators), attempt to not merely change labels but to implement real reforms, advisory and financial support from foreign countries, collaboration between governmental and public institutions and other stakeholders and also the development of realistic policies (Lember 2002). It was shown in this work that the health care system in Estonia corresponds to the Bismarck model from the OECD health care classification. Based on this fact, it was established that the health care system reforms were sensible. Considering what is known this far, they gave the best possible results to the present health care system in Estonia.

In recent years, the sustainability of the healthcare system financing is an issue of growing concern. As the life expectancy claims up but birth rate decreases and natural increase of population in Estonia stays negative, the taxpayers' pool is shrinking (Statistics Estonia 2016). On contrary, aging population and advances in healthcare technology drive up the costs. Not sufficient financing leads to poor healthcare access due to longer waiting times to see providers. In quest for solutions, some propose to turn to different healthcare models. Private insurance as in modified market model seems attractive to more affluent part of society, as it provides greater satisfaction for those who can afford it. It is crucial not to forget the core values Estonian healthcare system is based on, solidarity being the strength and cornerstone. Instead, the appropriate level of financing needs to be established for this well designed system to function properly. Other European countries spend around 7-9% of the national GDP on their healthcare. Estonia historically lags behind at around 6% of GDP, positioning itself next to Mexico (Health at a Glance 2015). So even while being recognized as (one of) the most efficient healthcare system in Europe for high quality of care at low expenditure (Björnberg 2016), it faces serious challenges of financial sustainability (Thomson 2010).

Conclusion

The health care system in Estonia functions according to the lines of the Bismarck model from the OECD health care classification. Based on this fact, it was established that the recent health care system reforms have been sensible. Considering what is known this far, they gave the best possible results to the present health care system in Estonia but in spite of this the sustainability of the healthcare system financing is an issue of growing concern.

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