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Overview of the Healthcare System in Estonia: A Personal View

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One of three Baltic states, Estonia covers an area of 45,227km 2, making it slightly bigger than Holland but with a population density ten times less. Estonia's population (1.34 million in 2006), has fallen by 13% since the collapse of the Soviet Union and its subsequent independence, due to emigration and a falling birth rate. Despite this, several success stories,e.g., continuous economic success and several e-initiatives (e-government, country-wide PACS etc.), provide hope for future growth.

About fifteen years after reobtaining independence, Estonia underwent radical economic reforms and widespread privatisation. A balanced budget, flat-rate income tax, a free trade regime, a fully convertible currency and a competitive commercial banking sector induced a massive influx of western investment during the 1990s and changed the economic orientation quickly. Successful monetary reform and the union with NATO and the EU led to further economic viability. However, some left-wing opinion leaders say that rapid economic success has pushed social security and welfare to the backburner.

Economic Growth and a Penny-Pinching Healthcare System

The 2001 Health Services Organisation Act specified that healthcare providers in Estonia would operate as private entities under private law. The aim of this policy was to decentralise hospital management but still preserve public influence through hospital supervisory boards. Therefore the majority of hospitals could be considered as public institutions. Primary care is mostly provided by family doctors (self-employed entrepreneurs).

13% of healthcare is funded through payroll tax, collected by the National Health Insurance Fund. During economic growth periods this guarantees a permanent increase of healthcare funding and reduces danger from political fluctuations. A simultaneous “separate and independent flow of health money” permits the Ministry of Finance to keep a distance from healthcare financing troubles. Therefore the share of healthcare costs arising from GDP in Estonia has remained around 5 - 5.4% for years, a lot less than the EU average (see fig. 1). The Ministry of Finance has set the goal to reach the 6.5% target by the year 2050.

Healthcare Pays the Price of Cost Containment Measures

In spite of the efforts of the medical community to increase funding for medical care, the ruling governing coalition prefers “Milton Friedman’s liberality and the doctrine of the thin state”. The Chairman of the National Health Insurance Fund has stated that “The Estonian healthcare system is the most cost-effective in Europe”. However, this cost-effectiveness is mostly achieved by forced low-price service contracts and strict budget constraints. Managers of surviving hospitals have to improvise ingeniously, cut costs, avoid unnecessary treatment, overdevelop profitable services and postpone investments into infrastructure and hospital buildings. For example, due to low-priced outpatient services in public hospitals (each twenty min. Specialist consultation costs approximately 10 Euro), there is no incentive to reduce waiting lists and patients are often forced to appeal to private institutions.

Another example of health cost containment for the state is the DRG policy. Hospitals are paid on the basis of fee for service, in general. This principal has been corrected by the “DRG-type” formula since 2004.

DRGs would in theory provide appropriate incentives to control costs and improve healthcare provision. Actually the DRG-formula in Estonia was introduced in quite a peculiar way, not offering incentives for care providers. Clinical fields are non-uniform and endure wide cost variance. For major hospitals the introduction of DRGs has resulted in a 3% loss of remuneration. Usually these losses are compensated by “counteractions” like service overproduction and cost inflation. This Machiavellian strategy means that while the ultimate objectives of DRGs are not attained, at least these fuzzy payment methods enable the Health Insurance Fund to control expenditures.

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Radiology in Estonia

Compared with other medical services, radiology and other diagnostic procedures are relatively fairly priced. The Estonian Society of Radiology has lobbied hard on this issue for years, enabling coverage of basic radiological needs in Estonia. The most common diagnostic procedure is still x-ray. In 2004, 750 x-ray exams and 351 ultrasonographies were made per 1000 population.

Modern computerised and more informative studies are also on the rise. The number of CT studies doubled during 2000 - 2004 (from 23 to 59 per 1000 population). A continuous increase in computerised studies is also expected in the future. In 2006, a boom in CT was noticed: five county hospitals of fourteen purchased their first new CT. Now there are 13 CTs per million in Estonia, above the European average (12). There are 2,3 MRI units per million, six times less than in neighbouring Finland.

60% of radiology departments are using digital radiography systems (mostly CR). Digital systems are preferred due to teleradiology opportunities and universal access to nationwide PACS. An archiving price of one

Euro per study is generally considered affordable by image producers. Family doctors have free access to all studies of their patient list.

Brain Drain in Estonia

The relatively low wages of medical personnel in Estonia and free movement of labour in the EU has led many doctors to neighbouring countries. Among other specialists, radiologists are in high demand. By some estimations 25% of medical students emigrate after graduation for residentship. To protest against underfinancing of healthcare and low wages, in January 2007 the Estonian Medical Association, which represents about half of all Estonian doctors, and the Estonian Nurses’ Union took strike action to combat the government’s reluctance to enter into negotiations. Fortunately the strike was avoided by negotiations and a 25% increase of the minimum wage was achieved. Due to high inflation rates and favourable market trends for medical professionals, similar actions may arise next year.

New developments in PACS and an open teleradiology market offer alternative options for radiologists despite questions of trust and medical malpractice liability still remaining unanswered. Several radiology departments in Tallinn offer diagnostic services to Denmark and the UK. Work is hard, but worth it - why not export services and stay at home with one’s family?

Conclusion

Estonia has bravely entered the European community. Due to its small size and bold political decisions, the country enjoys stable and dynamic economic development. In spite of economic success, healthcare professionals feel neglected and are expecting more proportional attention and further investments.

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