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Hospital reform in Bulgaria and Estonia: What is rational and what not?

Final report

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In memory of Ruta Kruuda (1967-2005)

This is the final report for the project "Hospital reform in Bulgaria and Estonia: What is rational and what not?", financed by the Local Government Initiative Fund of Open Society Institute, Budapest. The report compares hospital reform in two countries- Bulgaria and Estonia. The project has been led by Index Foundation in Bulgaria and the Center for Policy Studies Praxis in Estonia.

The report is written by Svetla Tsolova and Dina Balabanova (Bulgaria), Marge Reinap, Triin Habicht, Ain Aaviksoo, Agris Koppel and Maris Jesse (Estonia).

All inaccuracies and mistakes are entirely the responsibility of the authors.

The authors of the report would like to thank the team of the Institute for Social and Trade Union Research for their active part in conducting the field work nationally in Bulgaria. We are also grateful to the Bulgarian and Estonian hospital managers and health policy stakeholders who participated in the study.

Executive summary

"We should not rest on our laurels
but we need courage to take necessary steps for the future!"
(Estonian respondent)

The research undertaken in the framework of this project sought to contribute to the understanding of hospital reform in Bulgaria and Estonia by means of a detailed analysis of policies implemented in both countries aimed at rationalising the provision of hospital services. An analysis of theoretical and practical aspects of hospital reforms in the two countries was performed. A study collecting primary data of the views and attitudes of hospital managers and stakeholders with on the achievements and challenges in the reform of hospital care filed was conducted. In order to answer the research questions, a range of specific topics were selected: a) review of health and hospital reform strategies in Bulgaria and Estonia; b) hospital service delivery, decentralization and level of hospital autonomy; c) measures for improving hospital efficiency. The research employed several complementary research methods: literature review, postal survey of hospital managers and supervisory boards by means of semi-structured questionnaires, in-depth interviews with key informants using topic guides.

Reforming hospitals is a difficult process and health policy makers in most industrialised countries are facing challenges in responding to political pressures from different stakeholders, to satisfy societal demands for high quality of care, to assure financial sustainability of the public finances and to respond to the fast and radical changes that are taking place in the health care systems. In Bulgaria and Estonia, the implementation of a radical reform of health care delivery, and particularly of the role of the hospital and its place within the wider health care system, has also been complicated by a process of far-reaching political, economic, and societal change.

The literature review demonstrated a significant knowledge gap in research and analysis of hospital delivery models and its reform in Central and Eastern Europe, or specifically in Bulgaria and Estonia. There are few good quality publications, in peer-reviewed journals and elsewhere. These that are available suffer from methodological drawbacks. Some of the most relevant literature was published in non-peer-reviewed journals, in electronic format, or was not published at all, and therefore difficult to access. A major share consists of government-commissioned consultancy reports, small studies lacking a clearly described methodology, and personal communication. Comparative research on hospital care of Bulgaria and Estonia and its reform was not found, and generally, rigorous studies on health care delivery across countries in central and Eastern Europe were rare. This reinforced the rationale for this research, namely the importance of understanding hospital reform in relation to autonomy and new models of care across the two very different contexts, and identifying lessons for other countries in Europe seeking to reform their health care systems.

A theoretical framework was developed based on the World Bank approach and taking into account the WHO health system goals such as responsiveness, health, and fairness in financial contributions. It specified the following areas to be explored in our study:

external pressure; organizational structure and managerial instruments. Accordingly, the main topics (sections) of the questionnaires and topic guidelines for in-depth interviews for hospital managers, supervisory boards' representatives and key health policy makers are focused on: : health policy and hospital reform legislation; efficiency; resources (incl. financial and human), management and autonomy; access to and responsiveness of health care.

The hospital sector in Bulgaria and Estonia has undergone a series of structural, regulatory and financial changes over the last decade of dramatic political and economic transition. Although hospital reform has lagged behind the reform of primary health care, it has been intensified since 2000. In 2004, the share of health expenditures as percentage of GDP in both countries (in Bulgaria – 4.7%, in Estonia – 5.5%) was still below European countries average (EU15[1]- 9.3%). The underfinancing of the health sector and the reforms in the hospital care resulted in significant reduction of hospital beds. According to the WHO data, within one decade (from 1995 till 2004) the number of hospital beds per 100 000 population in Bulgaria (613.13) and in Estonia (581.79) fell below the European Union average (EU 25[2]- 649.61). A bit different is the situation with the number of hospitals per 100 000 where for the period 1995-2004 sharp reduction is observed in Estonia only. The current study did not find any significant reduction in the hospital capacity (beds and staff) in Bulgaria.

There is a similarity between Bulgaria and Estonia with respect to the role and power of the key stakeholders in health policy. Indeed, the stakeholders exercise different degree of influence over the governance and management of hospitals depending on the context in the individual countries. A significant difference is the active role of the hospital association in Estonia and its leverage on policy. In Bulgaria a number of hospital associations exist but their role is not very clear and they are still not seen as a key stakeholder in hospital care.

The perceived degree of clarity of the governmental policy on hospitals varies among different types of respondents participating in the survey. Interestingly, hospital staff is particularly critical in this respect in both countries. Although in Estonia a Master plan for hospitals has been adopted (a long term strategy for the period 2000-2015), the health facilities managers interviewed think that the state policy in health care and hospital reform does not have a clearly defined strategic objectives. Similarly, in Bulgaria, the predominant attitude is negative as well. The hospital managers in both countries believe that hospital care is not a priority on the government's health policy agenda. Opinions about the influence over the reform process differ in the two countries. In Bulgaria relatively small share of the respondents think that they can influence the reform process to any extent while, in Estonia, the majority of managers think that they can influence the formulation and implementation of hospital reform.

Changes in the mode of financing of hospitals, legislative changes, introduction of accreditation (licensing), free patients' choice, etc. are seen as positive aspects of the

[1] EU 15- European Union before 1 May 2004 with 15 member states.
[2] EU 25- European Union after 1 May 2004 with 25 member states.

reform process by the respondents in the both countries. However, the failure to implement fully some of these is seen as a negative aspect of the reform process. Shortages in funding and resources as well as poor implementation of initiatives are common negative aspects in both countries.

In both countries hospitals suffer from insufficient financing, which is seen as a crucial factor for effective hospital care. In Estonia some hospitals reported to have realised profit, and this is rare in Bulgaria, with any profit being spent on staff incentives, investment in equipment and infrastructure. It is not very common for the clinics and wards to be enabled to manage the funds in a fully autonomous manner. About a half of the respondents in both countries declare that clinics and wards have no financial autonomy.

Staff motivation, particularly a good remunerations are important factors for good quality of care and effectiveness. The study findings show that there is a link between remuneration and performed work. Yet the two countries experience problems with availability and qualification of human resources.

Importantly, in both countries management boards are reported to have a sufficient autonomy to perform their function, manage the hospital, especially in Estonia. The boards are also commonly seen to have responsibilities for all aspect of hospital operation, including managing debts. Notwithstanding the different level of autonomy reported, the objectives of the Bulgarian and Estonian hospital managers are very similar – quality improvement, efficiency, customers' satisfaction.

Health systems reform in the two countries led to creation of a market environment affecting financing and delivery of hospital care. Elements of competition among providers were introduced (in Estonia - 2003, in Bulgaria – 2004). Although majority of respondents in the two countries stated that there is competitive environment in the hospital sector, the Estonian managers perceive the environment in which they are working as more open for competition between the health care facilities than their Bulgarian colleagues. The opportunities to compete on quality of care depend very much on the conditions and resources in the hospitals. Overall, Estonian managers are more critical than their Bulgarian counterparts regarding the conditions of the infrastructure and medical equipment of their facilities. However overall, the hospital managers in both countries reported that the general condition of their buildings and equipment is acceptable.

In both countries the managers think that resources in the hospital sector could be used more efficiently. However, in Bulgaria managers were less critical about their own hospital compared to the hospital sector in general, while in Estonia the criticism was directed towards the performance of their own hospitals. Increasing control over costs and performed activities is perceived as a measure to improve efficiency in both countries. In order to achieve efficiency most of the hospitals in the two countries contract out some services to external providers, seeking to improve quality of services, release internal capacity and realise cost savings.

The study findings demonstrate that aspects of continuity of care can be problematic in both countries. The main problem is the insufficient collaboration between the different levels of care – primary, secondary, tertiary. Delayed referrals to hospitals by general practitioners, insufficient capacity for long-term (chronic) care and rehabilitation in order to ensure full recovery are common in both countries.

The study helped highlight a range of critical issues in relation to hospital reform. While some are context-specific, there are many common organizational, legislative, financial, human resources challenges, across the two countries, with the last two being most problematic. The highly politicised hospital governance was also identified as an obstructive factor. Policies should be directed to areas such as strengthening continuity of care, clarifying responsibilities for capital investments and development of public-private partnerships, implementation of standards for management and supervisory board activities, achieving a balance between retaining some vital social functions and market behaviour, elaboration and implementation of human resource strategy and integrated information systems. Stakeholders suggest that further hospital reform should take into account the main goals of health systems: efficiency, quality, solidarity and equity. It is suggested that cooperation between stakeholders should be enhanced in view of reducing policy fragmentation due to differential lobbying power of different groups. If the policy is directed toward giving a higher degree of freedom of hospitals, the policy makers have to assure that monitoring and benchmarking procedures are in place.

This research has addressed the attitudes of hospital managers and stakeholders with respect to the hospital reforms. Further research is needed to examine the views and attitudes of the general population and the opinion of the health care professionals from other levels of health system, as well as from related social sectors, regarding hospital reform and health reform in general. In both countries, a comprehensive evaluation of the current and future health care needs of the population. Other areas where analysis is needed is on the markets for hospital services – e.g. market concentration, Hospital ownership and hospital behaviour, role of prices regulations on the hospital behaviour, patient flows and ability to substitute among hospital providers, barriers to entry (costs, regulations, etc.) and their implications for the behaviour of hospitals, number, types and behaviours of buyers and respective consequences for hospital services. Systems for routine monitoring of hospital performance in view of needs and costs of care have to be developed to ensure adequate benchmarking and accreditation across hospitals. Health policy makers may consider strengthening health economics capacity within the respective ministries or specialized agencies for epidemiology and economic analysis in health care.

Introduction

Hospitals in most countries remain an important source of critical health care services, providing both basic and advanced care for the population. Despite much attention and emphasis on primary care as a first point of contact for patients, hospitals remain the most important element of health care provision for example, comprising the largest share of total health expenditure. They are viewed by the public as the main manifestation of the health care system and its ability to fulfil a caring role, and are therefore, significant politically (McKee & Healy, 2000; Wiley 1998).

Hospitals are often the target of health sector reforms aimed at efficiency, equity, and quality improvements. They also play a key role in system-wide reforms in financing and health care delivery, health policy framework, provider payment mechanisms, and competitive market environment (Preker & Harding, 2003; Harding & Preker, 2000). There is a consensus that they must change in response to: a) demand-side pressures such as the changing demographic status and health needs of the population in industrialised countries(evolving patterns of disease: increases in chronic conditions, localisation of infectious diseases among certain groups,), b) supply-side pressures such as scarcity of resources in the face of new technologies (including advances in pharmaceuticals, technology, and new organizational models transferring some of the care to the home), and c) changing public expectations about the role of the hospitals as a consequence of wider societal and economic change (McKee & Healy 2002). Other authors point to other substantial pressures on hospitals requiring fundamental change in the way they operate (e.g. centralization or decentralization in each context): increasing specialisation in health care, changes in employment practice, improved efficiency, safety, quality and volume of services, technology, and consumerism (Edwards et al, 2004).

Yet, reforming hospitals poses significant challenges. As McKee and Healy (2002) point out, the hospital sectors have prove difficult to change in most settings, both structurally and culturally, despite the recognized need for change. Their infrastructure largely predetermines the capacity and opportunity for reform, and flexibility as to reform options is often limited. Hospital functions are also resistant to change and traditionally conservative.

Hospital reforms tend to be politically sensitive and are often avoided by policy-makers. Many of the difficulties in hospital reforms have had more to do with the complexity of changing clinical and managerial practice than with the actual reform content, with the success of reform largely dependant on the ability of policy-makers to manage change. The reform debate focuses increasingly on those contextual and process factors that enable or obstruct change, including relationships between stakeholders, effective stewardship, steering implementation processes, and building institutional, human and management capacity (Figueras et al, 2002).

Once built, hospitals have proved to be almost impossible to close and difficult to reform. Discussing the downsizing, privatisation or closure of local hospital is seen as politically

highly charged (Rethelyi et al, 2002). Building and running hospitals absorbs the major share of health expenditure in any country. As demand for hospital care increases and the costs of provision rise, it is essential to make more efficient use of the resources already devoted to hospitals. Most countries face high demands on their health care systems and a limited budget to meet these demands. The evolution of health expenditures is a major constraint for health policy and health planning. Ageing of the population will further threaten sustainability of public spending on health care and require cost containment of.

In Central and Eastern Europe (CEE) far-reaching reform of health care delivery, and in particular of the role of the hospital and its place within the wider health care system, has faced additional difficulties due to dynamic reform process after 1989. The challenges include the changing political context, with its gradual shift from a highly centralised, planned approach to a more pluralist model involving an increasing number of policy players. A further problem is that, to a large extent, hospitals in CEE still serve different functions to those in much of western Europe; having been designed as dominant providers not only of health care, but also of a large part of social care given that community care services (apart from the family) are rare.

Organizational changes in the hospital sector have been a common component of health reform throughout Central and Eastern Europe during the 1990s (Preker et. al, 2002). Hospital restructuring has aimed to reduce the excess capacity in many CEE countries (Afford, 2003). There have been cuts in bed numbers, but these have been patchy across the region. However, a strategy focused on bed closures fails to address the specific role of hospitals as tertiary and long-term care providers, with little alternative social care support systems. The reduction in bed numbers has been easier to achieve, rather than change the functions of entire hospitals. Moreover, reduction beds have not always achieved significant savings since a considerable proportion of hospital cost is associated with buildings and other fixed costs. Decentralisation of management, combined with shifts in payment mechanisms has been also implemented in order to improve performance (Figueras et al., 2002).

A range of initiatives to improve hospital efficiency have been undertaken by health policy makers across central and eastern Europe, including:

- More efficient use of resources available across the health system, by reviewing the numbers of hospitals and their distribution, to see whether resources can be better allocated between hospitals and regions, for example by reducing duplication of services or closing some hospitals.
- Increasing hospital autonomy and giving managers clear responsibility for improving performance, so they can make decisions quicker based on local conditions and priorities, rather than following centrally determined decisions and regulations.
- Introducing measures to promote a more efficient use of the resources available to the hospital sector, for example by cutting down wastage and corruption in purchasing of supplies, using generic rather than branded drugs, improving

procedures and rationalising staff levels and mix to achieve more patient throughput relative to staff inputs.

These approaches are related: greater hospital autonomy with clear responsibility and accountability means that hospital managers have incentives and opportunities to introduce efficiency improvement measures in their hospitals. Whilst these approaches to improving efficiency are relatively straightforward in principle, the political and organisational realities complicate matters in practice.

The policy makers' strategies for reform and the impact of actual hospital restructuring on hospital operation, staff incentives, on quality of care and on the overall health system performance, have not been evaluated comprehensively in any of the CEE countries. This study aims to assess the implementation of hospital autonomy as a central element of all reform strategies and the rationalisation of hospital care in two CEE countries – Bulgaria and Estonia.

Research methodology

The Team

The study within the project "Provision of hospital services in Bulgaria and Estonia – What is rational and what not?" was conducted by Index foundation (Bulgaria)[3] and Praxis (Estonia). Index Foundation was established in 1997 as a not-for-profit organization with a mission to promote the development of civil society in Bulgaria and contribute towards strengthening the social safety nets. Index Foundation works in several major areas - education and training, research, health care, prevention of drug use. A range of people provided input into the project: Svetla Tsolova (Research fellow in Center for European policy studies), Dina Balabanova (Lecturer in LSHTM, London), Galina Kanazireva (Executive director, Index foundation), Ljudmila Mincheva – (Chairwoman, Index foundation), Silvia Duncheva (Project manager, Index foundation), Ljuben Tomev (Director, Institute for Social and Trade Union Research), Violeta Ivanova, Angelina Nikolova, Zinaida Naydenova and Diana Trakieva (researchers at Institute for Social and Trade Research).

PRAXIS Center for Policy Studies is an independent not-for-profit think-tank based in Tallinn, Estonia. Founded in 2000, the mission of PRAXIS is to improve and contribute to the policy-making process in Estonia by conducting independent research, providing strategic counsel to policy makers and fostering public debate. The team involved in the project included: Ruta Kruuda (who tragically died at the very beginning of the project), Ain Aaviksoo (Program Director, Praxis), Agris Koppel (Analyst, Praxis), Maris Jesse (Senior Health Specialist, World Bank), Triin Habicht (Estonian Health Insurance Fund), Marge Reinap (Ministry of Social Affairs).

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[3] For the field work in Bulgaria Index Foundation collaborated with the Institute for Social and Trade Union Research.

The study was undertaken in the period September 2005 – December 2006 and was funded by the Open Society Fund, Local Government Initiative, Budapest. The research component of the project was conducted in several steps:

- Literature review (October 2005- January 2006)
- Development of framework and research tools (questionnaires and topic guides) (February – May 2006)
- Postal survey for directors and other managerial staff of hospitals (June- August 2006)
- Postal survey with representatives of supervisory boards (Estonia) (September 2006)
- Interviews with key stakeholders (incl. hospital directors) (July – September 2006)
- Two national-level round tables – in Sofia and Tallinn (September and October 2006)
- International conference in Sofia to disseminate project outputs (November 2006)
- Final report (December 2006)

Aims of the research

The research seeks to contribute to the understanding of hospital reform in Bulgaria and Estonia by means of a detailed analysis of hospital reform policies implemented in both countries seeking to rationalise the provision of hospital services. The aims of the research are as follows:

- Analysis of theoretical and practical aspects, achievements and challenges of hospital reform strategies and their impact on restructuring and improving hospital care delivery.
- Analysis of the policy for rationalisation of the hospital sector, which is expected to lead to improvements of quality and effectiveness of hospital care.

For the analysis the following topics have been selected:

- Review of health sector and hospital reform strategies in Bulgaria and Estonia;
- Decentralisation and hospital autonomy, and impact of these reforms on actual practice, according to managers
- Specific measures for improving hospital efficiency and their impact

Methods

The research employed several complementary research methods: literature review, postal survey for hospital managers and supervisory boards by means of structured questionnaires including some open-ended questions, in-depth interviews with key informants using topic guides.

Literature review

The literature review covered a broad range of sources. These included published government documents, legislation, policy strategies, institutional plans for hospital restructuring prepared by the Ministry of Health (Social Affairs), Health Insurance Funds, Parliamentary Health Committees, regional authorities, international agency reports and loan documentation, and others. Unpublished technical assistance reports relevant to the study were also reviewed. Strategy documents published by key stakeholders have been reviewed, as well as consultancy reports presented to the government agencies in both countries. Web sites of the Bulgarian Ministry of Health, Estonian Ministry of Social Affairs, Parliamentarian Health Committees, Health Insurance Funds, the Physicians' Unions, Municipal Associations and other research and policy institutes have also been reviewed for policy documents, working papers, policy statements.

Literature review of relevant papers published in books and in peer-reviewed journals was also conducted. Sources were located after an extensive search of databases, advice from experts, and various library and web resources. Databases used included: Social Science Research Network (www.ssrn.com); RePEc – Research papers in Economics, (http://econpapers.repec.org/); National Bureau for Economic Research (www.nber.org) and its subsection 'health'; Google Scholar; J STOR publisher, etc. The main search terms were 'hospital reforms', 'reorganisation/rationalisation of health care services'; 'inpatient provision of health care', 'health care reforms in CEEC', 'hospital reform in Bulgaria', 'hospital reform in Estonia', 'payment for hospital provision', 'financing inpatient care', 'accreditation of hospitals', etc. Priority was given to the academic literature and to publications of major developmental agencies such as World Health Organization (WHO), the European Observatory on Health Systems and Policies, World Bank, Organization for Economic Cooperation and Development (OECD), International Labour Organization (ILO), the European Commission, etc.

In *Social Science Research Network* database there were no matches for "Bulgarian and Estonian hospital care". Two publications were listed under health reform in Bulgaria: Managing Fiscal Risk in Bulgaria (2004) by Hana Polackova, Sergei Shatalov and Leila Zlaoui, publication of the World Bank (WB Policy Research Working Paper No. 2282) and How Does the Introduction of Health Insurance Change the Equity in the Health Care Provision in Bulgaria? (2007) by Nora Markova, publication of IMF (Working Paper No. 06/285). No publications for Estonia were found in this database. In *RePEc – Research papers in Economics* only one broad study on Bulgarian health reform was found - Healthcare Reforms in Bulgaria: Towards Diagnosis and Prescription (2006) by Konstantin Pashev, CSD. No studies on Estonia had been found in this database. There is not a single research study in *NBER database* on health care (hospital reform) neither for Bulgaria, nor for Estonia. In *IngentaConnect* database there were no articles on hospital reform in Bulgaria and Estonia. For Estonia only one article matched the search on health reform: Midwifery at the crossroads in Estonia: attitudes of midwives and other key stakeholders (2005) by Lazarus, JV.,Rasch, V;Liljestrand, J, Acta Obstetricia et

Gynecologica Scandinavica, Volume 84,Number 4, April 2005, pp. 339-348(10). Few articles matched the search for health care reform in Bulgaria:

- Balabanova D.;McKee M. Reforming health care financing in Bulgaria: the population perspective (2004).Social Science and Medicine, Volume 58,Number 4, February 2004, pp. 753-765(13)
- Popova ST, Kerekovska AG. A critical review of primary health care reform in Bulgaria: impact on consumers (2001).., International Journal of Consumer Studies, Volume 25,Number 2, June 2001, pp. 123-131(9)

In ***Health Policy*** there are four articles addressing health reform in Bulgaria more generally: a) Balabanova D, McKee M. Understanding informal payments for health care: the example of Bulgaria by, Volume 62, Issue 3, December 2002, pp. 243-273; b) Pavlova M, Groot W, van Merode G. Public attitudes towards patient payments in Bulgarian public health care sector: results of a household survey., Volume 59, Issue 1, January 2002, pp. 1-24; c) Pavlova M, Groot W, van Merode F. Appraising the financial reform in Bulgarian public health care sector: the health insurance act of 1998. Volume 53, Issue 3, 1 October 2000, pp. 185-199; d) Delcheva E, Balabanova D, McKee M. Under-the-counter payments for health care. *Health Policy,* 1997; **42**: 89-100.
For Estonia there are also few articles on general health reform: a) Atun RA, Menabde N, Saluvere K, Jesse M and Habicht J. Introducing a complex health innovation—Primary health care reforms in Estonia (multi-methods evaluation). Volume 79, Issue 1, November 2006, pp.: 79-91; b) Põlluste K, Kalda R, Lember M. Satisfaction with the access to the health services of the people with chronic conditions in Estonia by (In Press, Available online 29 September 2006; c) Fidler AH, Haslinger RR, Hofmarcher MM, Jesse M, and Palu T. Incorporation of public hospitals: A “Silver Bullet” against overcapacity, managerial bottlenecks and resource constraints?: Case studies from Austria and Estonia by, In Press, Available online 17 August 2006; d) Gibis B, Artiles J, Corabian P, Meiesaar K, Koppel A, Jacobs P, Serrano P, Menon D. Application of strengths, weaknesses, opportunities and threats analysis in the development of a health technology assessment program. Volume 58, Issue 1, October 2001, pp. 27-35.

In ***Health Policy and Planning Journal*** (Oxford University Press) only one article had been found for Estonia: Habicht J, Xu K, Couffinhal A, Kutzin J. Detecting changes in financial protection: creating evidence for policy in Estonia (2006).Health Policy and Planning 2006 21(6):421-431.

Evidence from the literature is incorporated thematically within the report. The review demonstrated that there is a scarcity of available articles on health reform in the two countries. This is particularly problematic for hospital financing and delivery, with the search on “hospital reforms” finding almost no publications in international journals. Moreover, the most relevant literature was either not published in peer-reviewed journals, or was unpublished and difficult to access. A major share consists of government-commissioned consultancy reports, small studies lacking clearly described methodology, and personal communication. The research team was not been able to find any articles that refer to comparisons of the Bulgarian and Estonian health and in particular hospital care systems, even within a broader discussion of health care reform in central and

eastern Europe. The review of the government and consultancy reports highlights the following emerging themes: health policy framework and hospital sector reforms; challenges for hospital reform (incl. clearly stated objectives and chronology - pace of reform, political debate/implementation); regulatory framework; implementation; monitoring and evaluation (formal procedure implemented by the government for monitoring and evaluation).

A brief analysis of the main issues discussed in the reviewed government and consultancy reports and strategies shows that the health sector reforms in Estonia in the past 15 years have been radical. The pace of change has been rapid, starting with introduction of health insurance in early 1990s followed by extensive primary care and hospital reforms. Hospital sector reform was re-initiated in the late 1990s, when the Hospital Master Plan 2015 was prepared. The goal of Hospital Master Plan 2015 was to downsize the hospital network capacity for acute care and to improve the efficiency of the hospital sector through mergers and restructuring. There has been a significant progress towards achieving the reform objectives envisaged in the Master Plan, with the number of acute care hospitals falling from 143 in 1980 to 50 in 2003 and the average length of stay declining to 6.4 days in 2003 (compared to 8.8 days in 1998). However, analysts suggest that a further optimisation of hospital sector is needed to use the available resources more effectively, but further implementation should be in line with strengthening primary and long-term care.

The main issues in terms of strategic purchasing in the hospital sector focus on the contracting process between the Health Insurance Fund and hospitals as providers. The Estonian health insurance system is based on strictly balanced budget principle and this principle is also followed in the contracting process. The process of contract negotiations can be seen in two phases. During the first phase standard contractual conditions are agreed with the Hospital Association representing all hospitals, and during the second phase, contract volumes and average cost per case are negotiated with each separate provider. The Health Insurance Fund covers only costs that do not exceed the agreed contract volume and providers are responsible for any additional expenditures. Service prices and payment methods are set ex ante and are not an important part of the contracting process.

The market environment is not very well developed in the Estonian hospital sector. There are barriers to entry into the market (minimum standards) and limitations to entry into a contract with the Health Insurance Fund, but these do not have a significant influence over the competitive behaviour of providers and therefore have a limited impact on hospital performance. Recently the Health Insurance Fund has been introducing some selective contracting for out-patient specialist care but this has had a rather limited effect.

Hospital governance is an area of growing interest in Estonia. Most of the Estonian hospitals are hospitals operate under private not public law (i.e. even when the ownership is in a public sector – state or municipalities) and they have same legal environment as private companies. The Estonian hospitals have management boards that are overseen by multi-representative supervisory boards, where mainly owners' interests are represented. However, there are ongoing discussions about what should be the appropriate composition of the supervisory boards and whether they act in public interests as expected. The role and responsibilities of hospital supervisory boards are also

increasingly debated. Governance is identified in a range of publications, as a critical area where changes are required in order to further improve hospital sector performance. Due to the importance of this area and the limited evidence available for Estonia, this topic is covered by the postal survey for hospital managers and supervisory boards within this project.

The health system of Bulgaria, as in all former socialist countries, was based on the Soviet Semashko model, which was characterized by the dominance of hospitals accounting for about 60-75% of total health expenditure. Thus, extending hospital infrastructure and training more doctors was considered essential for improving effectiveness of health care delivery. The national health policy was focused on quantity rather than quality of services, with political goals taking priority over public health needs. Provision was centralised, with specialised and tertiary hospitals seen as more prestigious employing the best qualified doctors, and receiving a larger share of resources compared to smaller region-based hospitals. The needs from provision in the area of paediatrics, maternity care, infectious diseases such as tuberculosis, and especially in some subspecialties within each of these fields, were overestimated. Furthermore, a great number of 'narrow' specialists worked in polyclinics (primary care practices) along with district physicians (generalists with limited role in patient care), with both groups having strong incentives to refer rather than treat patients (Koulaksazov, et al., 2003). Seeking to reform hospital care, in 2002 the Bulgarian Ministry of Health has developed a hospital reform strategy for the period 2002-2006 that was latter adopted by the Council of Ministers as a government policy (Ministry of Health, 2002). In 2006 new strategy has been developed for the period 2007-2012 which is yet to be adopted by the government.

Before hospital rationalisation could be implemented, the needs of the population have to be assessed (at national, regional and municipal level) in order to compare available health care facilities to the needs and levels of utilisation, and to plan improvements (Bearing point, 2003). However, planning in Bulgaria has been hampered by the lack of integrated information systems allowing to measure activity rather than infrastructure (e.g. ration of staff to population or beds to population). Currently, data on clinical activity is collected separately by the MoH and the NHIF, with the two flows not integrated, and not immediately accessible to health care planners and other stakeholders.

These reform objectives could be analysed using the Neubauer's typology that distinguishes between four generic objectives of hospital reform in Europe: a) financing of hospital investment, including major equipment, b) integration of outpatient with inpatient care, c) improving hospital management and d) changing the reimbursement of hospitals into a case-based prospective payment (Neubauer, 1993). Clearly, in Bulgaria there has been attention to some of these such as building management capacity, but a relative lack of attention to long-term investment (technology and infrastructure) and integration of care. As shown by the results of our study, this lack of explicit targeting of some of the major reform elements may have been limiting.

Given the limited availability of relevant and methodologically sound studies on Bulgarian and Estonian hospital reform, and in Central and Eastern Europe in general the emphasis of the study has been on the collection and analysis of primary data, in

responding to the study objectives. The main areas of hospital reforms in both countries that are studied during the project are external environment, organisational structure and managerial issues. It was agreed that the literature review will cover mainly the first area – external environment, while the other two will be studied in more depth through the survey and the interviews. The comparative approach and identifying commonalities and differences can be considered as a contribution of the research team toward better understanding of the reform processes in these countries.

Postal survey of hospital staff in senior management positions

The postal survey questionnaires for hospital managers were developed, pre-tested and finalised in close collaboration between the Estonian and Bulgarian teams, to ensure cross-country comparability. The questionnaire drew on the main themes that emerged from the documentary analysis and in-depth interviews with stakeholders.

About a third of the questions in the survey questionnaire were the same for Bulgaria and Estonia, with the rest addressing country-specific issues to inform national-level debate. For example, the Estonian survey contains few questions about number of beds, staff and financing sources as during the piloting this was found to significantly reduce the response rate. Instead, such data were obtained from other sources such as routine statistics and publicly available survey data. In Bulgaria, a separate questionnaire collecting data on hospital capacity, salaries, revenue and expenditure was developed and filled by a respondent with an access to such data in each hospital. Three other questionnaires per hospital were completed by hospital managers. These required mostly information on the views and attitudes of managerial staff to hospital reform and aspects of facility management (3 questionnaires per hospital). The questionnaires contained a mix of closed and open-ended questions allowing to elicit respondents' own perceptions.

The surveys for hospital managers were piloted in Estonia (with three hospital managers) and in Bulgaria (with four hospital directors) and the questionnaire was revised according to the received comments. After piloting, the final version of the questionnaire was agreed between the partners in the two countries, with the main sections including: background information, health care policy and reforms, legislation, efficiency, resource and cost management, autonomy and management, financing, access and continuity of care and human resources. There was an effort to limit the length of the questionnaires in order to improve completion rate. The questionnaires were sent with an accompanying letter stating the aims of the study and the purpose of the research and seeking to obtain informed consent. Confidentiality procedures were guaranteed and maintained.

In Estonia questionnaires were sent to all 50 hospitals – a total of 83 personal questionnaires were posted to the members of the management boards. These were addressed to the heads of management boards and to all management boards' members of the Master Plan hospitals (19 in total). In the bigger hospitals where the management boards consist of several members, more than one questionnaire per hospital was sent. 36 questionnaires were returned, with 34 fully completed; a response rate of 43%. A second round of questionnaires with reminders was sent to 49 hospital managers who did not responded initially. The response rate of the second round was 27% (13 returned questionnaires) and only one questionnaire was not completed. In total, out of 83 targeted managers, 46 completed questionnaires were returned (55% response rate).

In Bulgaria the questionnaires (one questionnaire collecting hospital-level information, and three individual-level questionnaires per hospital) were sent to 207 hospitals (out of 262 hospitals in total). The sample covered a variety of hospitals in terms of profile, functions, and geographical coverage, but excluded private hospitals and hospitals subordinated to institutions other than Ministry of Health. During data entry and analysis hospital- and individual-level information were matched for each health facility, while safeguarding anonymity of the respondents. By the end of August 2006, 61 completed

questionnaire for hospital-level information were returned (response rate of 30% out of 207) and 161 individual questionnaires (response rate 26% out of 161). There were efforts to increase the response rate through follow-up by telephone, but this was not successful. Instead, the research team conducted more in-depth interviews with hospital directors than initially planned in order to compensate for the relatively low response rate in the survey.

It was agreed that separate postal survey among hospital supervisory board members will be conducted in Estonia) as governance in the hospital sector is seen as an extremely important area that should be addressed by reform. These issues are less relevant in Bulgaria where few hospitals have supervisory boards (8.5% of the hospitals in the survey had an equivalent board).

The questionnaire for supervisory board members in the Estonian hospitals included about a half of the questions from the survey of the management board members. This made it possible to compare the attitudes and opinions of hospital managers and governors. The other half of the questionnaire was specific to the supervisory boards. The topics covered in the questionnaires refer to health policy and reforms; legislation, resource and cost management, hospital management and governance, financing, and responsiveness of care. The questionnaire was also much shorter. In total, 39 questionnaires were sent out in June 2006, covering 7 regional and central hospital supervisory boards. Compared to the management boards survey, the response rate was low – only 9 filled questionnaires were received; a response rate of 23%. The questionnaires were then re-sent and four additional responses were received, thus increasing the response rate to 33%. In order to retain the anonymity of the respondents the codes on the questionnaires were used only to distinguish between the respondents, and the names and the codes were never compiled in the same database.

In-depth interviews with key informants

In order to analyse their role in hospital care and its reform, in-depth interviews with key stakeholders were also performed. The interviews aimed to identify the factors that have facilitated or obstructed hospital reform, allowing for new themes to emerge. A flexible interview guide was used allowing open discussion around a pre-defined framework. In each interview, different areas were emphasised according to the respondent's individual expertise. The topic areas covered included: health policy, hospital reform, legislation; efficiency; management and autonomy; ownership and management; accessibility of medical care and financing.

In Bulgaria, 26 key informant interviews were conducted, with high-level managerial staff, public health officials, and national-level stakeholders in health policy using a semi structured topic guide. 18 interviews were with hospital directors. Initially the team had planned less than 10 in-depth interviews with hospital directors, but this number was later increased due to the low response rate in the survey. In addition, eight interviews with stakeholders with an active role in health policy making, able to influence policy or having a detailed understanding of policy developments were undertaken. These were representatives of the Ministry of Health (1), the Bulgarian Physician's Union (2), Trade

unions (1), Members of the Parliamentarian health committee (2), Hospital association (1), the National Health Insurance Fund (1).

In Estonia, nine in-depth interviews with key informants took place, out of 10 planned. The respondents included hospital managers, hospital supervisory board members, representatives of the Estonian Health Insurance Fund and Ministry of Social Affairs. Three different versions of the interview questionnaires were prepared depending on the position of the respondent. Main topics that were covered during the interviews were: hospital sector reform in general, roles of the management and supervisory boards, hospital ownership and legal status with relevance to the facility management, and politicisation of hospital's boards.

Contribution of the research project

The main aim of the project is to review the key steps in the hospital sector reform in Bulgaria and Estonia. It also sought to understand the degree of autonomy of the hospital managers and to what extent they are able and motivated to implement measures for improving the effectiveness and efficiency of hospital care. However, the primary focus of this study was on institutions and individuals directly involved in managing or regulating hospitals, as well as the market and regulatory environment within which they operate. Due to time and budget constraints, the views and attitudes of staff working at other levels of the health systems (e.g. primary care) or in other sectors (e.g. social services), hospital users and public attitudes in general, were not examined, and have to be addressed in future research.

The project seeks to contribute to a broader understanding of the effective strategies to ensure that hospital delivery in post-communist countries can respond to changing population health needs and fit with the new economic realities, such as a decreased public funding for health care. Clearly, the issues explored in this research are not unique to countries in transition, the findings of this study provide lessons that are relevant also to other countries facing similar challenges and seeking to transform their hospital sectors, in central and eastern Europe and the former Soviet Union as well as in other low-income countries. Yet, the study is the first attempt to compare two countries that had very similar starting positions 15-16 years ago (in terms of organisation, financing and legislative framework of their health care systems) but are currently in different stages of their development with respect to the hospital reform process.

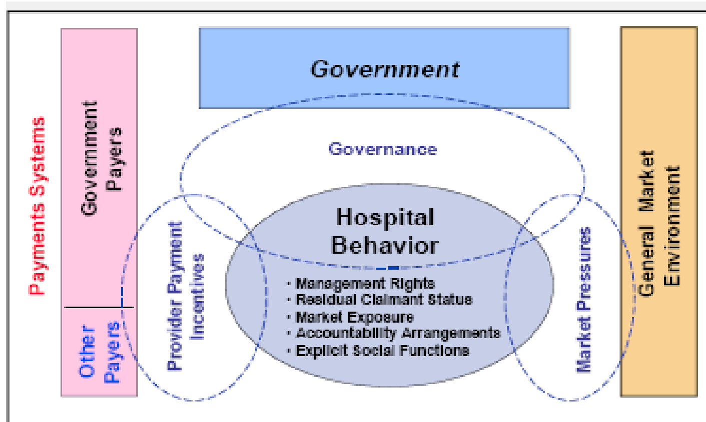
Theoretical framework

Relevant publications of the European Observatory on Health Systems and Policies of the WHO regional office for Europe (www.observatory.dk) have informed the conception as well as key stages of the study, e.g. Health care systems in transition – country studies for Bulgaria (2003) and Estonia (2004), Policy brief no. 5 (2004) "Configuring the hospital for the 21st century"; Hospitals in a changing Europe" (2002), edited by Martin McKee and Judith Healy, etc.

However, the theoretical framework for this study mostly draws on the World Bank publications (division Health, Nutrition and Population family - HNP) - "Understanding organizational reforms. The corporatization of public hospitals" by April Harding and Alexander Preker (September 2000) and "The introduction of Market forces in the public Hospital Sector. From New Public Sector Management to Organizational reform" (June 2002) by Melita Jakab, Aleksander Preker, April Harding and Loraine Hawkins. The authors of these studies emphasise that the organisational reform is often a core component of health sector reform in many different settings. These changes are designed to improve the incentive environment by altering the distribution of decision-making control, revenue rights, and hence risk among participants in the health sector. There is a wide range of organisational reforms. Some focus on changing the mapping of functions across agencies, for instance, creating health insurance agencies that collect premiums and purchase health services. Decentralization is another common organisational reform in the health sector, a reform that shifts decision-making control and often revenue rights and responsibilities from central to lower level government agencies (Harding and Preker, 2000).

Harding and Preker (2000) emphasise that many public hospitals and clinics operate as part of the integrated government structure, usually as a form of budgetary organisation (i.e., government department). The reforms applied to such organizations vary in magnitude, depending on where the organisation is located on the public-private continuum. There are three sets of systemic factors jointly determining the incentive regime and hence behavior of publicly-run health service providers undergoing such reforms. These include: a) alterations to the relationship between health care providers and governments (governance); b) the market environment to which such organizations are exposed, and c) the incentives embedded in the funding or payment mechanisms (provider payment systems). (Figure 1) These three factors exert a powerful influence on the behavior of the hospitals and create the critical elements of the incentive regime that the hospitals face: allocation of decision rights, distribution of residual claims, degree of market exposure, structure of accountability mechanisms, and provisions for social functions. The organisational forms vary substantially in the amount of autonomy given to the managers, the mechanisms used to generate new incentives, and accountability.

Figure 1: Key Determinants Changes in Organizational Behavior

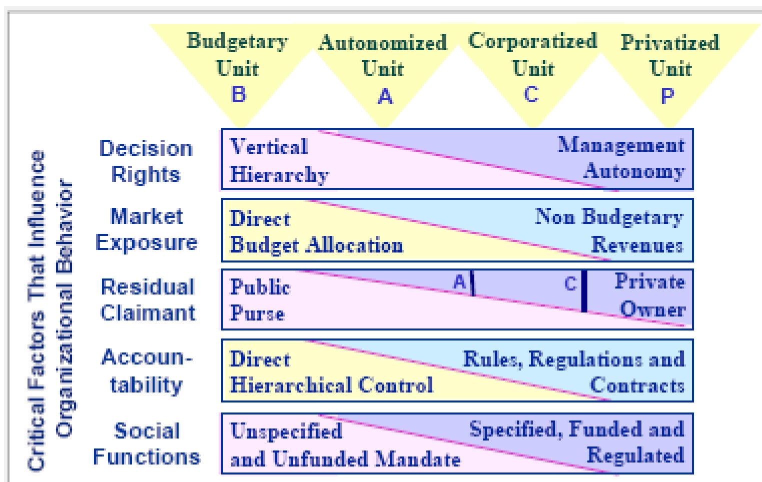


Source: Harding and Preker, (2000)

Each reform can be characterised by the degree of control shifted from the hierarchy, or supervising agency, to the hospital. (Figure 2) Critical decision rights transferred to management may include control over inputs, labor, scope of activities, financial management, clinical and nonclinical administration, strategic management (formulation of institutional objectives), market strategy, and sales. A critical distinguishing feature of the reforms is the degree to which the public purse ceases to be the "residual claimant" on revenue flows. Aligning the revenue flows and decision rights is crucial to get those in the right place to make the right decisions. A high-powered incentive is the degree to which revenue is earned in a market, rather than through direct budget allocation. The reforms are also characterised by the degree, to which accountability for achieving objectives is based on hierarchical supervision of the organization versus regulation or contracting. As decision rights are delegated to the organisation, the government's ability to assert direct accountability (through the hierarchy) is diminished. Partially, accountability is intended to come from market pressures, since the market is seen as generating a nonpolitical, nonarbitrary evaluation of organisational performance, at least its economic performance. If the government is a purchaser, accountability will also be pursued via the contracting and monitoring process. In the health sector, markets often cannot deliver on health policy objectives—both due to market failures and due to social values. Thus, rules and regulations regarding the operation of these organisations constitute an alternative form of accountability mechanism.

Strengthening these mechanisms constitutes a fourth critical element of organisational reforms that reduce the use of traditional, hierarchical accountability mechanisms. The final critical factor characterising these organizational reforms is the degree, to which "social functions" delivered by the hospital shift from being implicit and unfunded to specified and directly funded. Two external elements strongly influence the new incentive regime: the funding or payments arrangements; and the structure of the market to which the organization is exposed (Harding and Preker, 2000).

Figure 2: Combined elements of governance arrangements to achieve efficiency



Source: Harding and Preker, (2000)

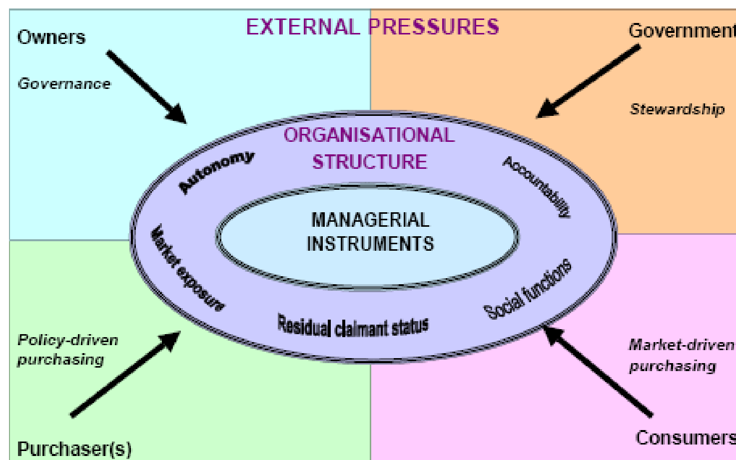
A hospital's overall incentive regime can be decomposed into pressures originating from the external environment and pressures originating from the hospital's organisational

structure. Managerial instruments allow hospitals to respond to the pressures of the incentive regime. Changes in hospital organisational structure through autonomisation and corporatisation have been increasingly applied over the past decade in many countries and thus there has been an upsurge in interest in better understanding how hospital organisational structure contributes to performance.

Organizational structure consists of five key components: allocation of decision rights (autonomy), market exposure, residual claimant status, accountability structures, and social functions. The second building block of this course is to understand the pressures put on hospitals by the external environment. These pressures come from the relationship of the hospital with other actors in the health system. External pressures originate from four main sources: government oversight, organized purchasing, market pressures and ownership (Figure 3).

- Government oversight. The basic task of government oversight in the health sector is threefold: formulating health policy by defining vision and direction for the sector; regulating the actors in the health system; and collecting and using information;
- Organised purchasing. The hospital's relationship with the collective purchaser(s) determines the financial incentives embedded in the payment mechanisms and the extent of competitive pressures on hospitals from organised collective purchasers;
- Market pressures. The hospital's relationship with its consumers (market-driven purchasing) determines the extent of competitive pressures the hospital is subject to from unorganized individual consumers exercised through choice and user fees;
- Ownership (governance). Governance is commonly defined as the relationship between the owner and management of an organization.

Figure 3: Determinants of hospital behavior

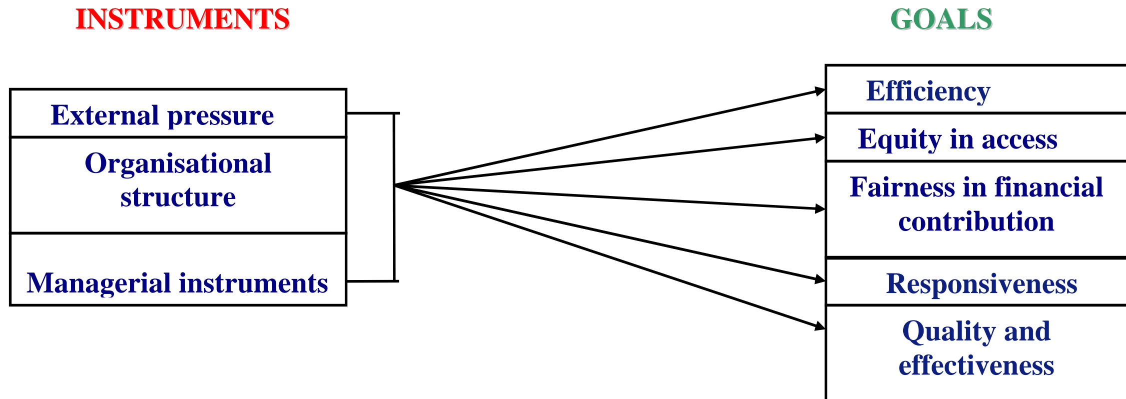


Source: Jacab et al., (2002)

Good governance is said to exist when managers closely pursue the owners' objectives rather than their own. Governance in public hospitals is often problematic because the owners are physically far removed from management and cannot directly observe their actions and hold them accountable. These four functions are not necessarily separated from each other (Jakab et al, 2002).

Drawing on the reviewed World Bank approach and seeking to incorporate the WHO health system goals - responsiveness, health, and fairness in financial contributions, the research team specified the following areas to be explored in the study: external pressure; organisational structure and managerial instruments. The framework for the study is presented below (Figure 4).

Figure 4: Framework of the study



Source: Authors

The main areas to be explored could be operationalised into several sub-issues listed in Table 1.

Table 1: Main areas and sub-areas of the study framework

External pressure	Government oversight	• Health policy framework and hospital sector reforms • Regulatory framework • Monitoring and evaluation
	Strategic purchasing	
	Market environment	• Barriers to entry and exit (minimum standards and licensing, selective contracting, competitive tendering of selected services, sector neutral competition) • Contestability (competition not for market share at any given time period but competition over time) • Yardstick competition (use of comparative provider performance indicators)
	Governance by owners	• Owners objectives and criteria's for management performance • Structure of supervisory management • Responsibility for supervising management • Monitoring and motivation of management
Organizational structure	Autonomy	• Decision rights over labor • Decision rights over capital assets

		• Decision rights over setting user fees
	Market exposure	• Hospital performance impact on revenues • Hospital competition in labor and capital assets market
	Residual claimant status	
	Accountability	• Accountability instruments between the hospital and patients (patient grievance procedures, community representation on hospital boards) • Accountability instruments between the hospital and payers (audits, contracts with performance objectives, comparative provider performance information) • Accountability instruments between the hospital and owners (community and business leaders representation on hospital boards, business plans) • Accountability instruments between the hospital and regulators (minimum standards, outcome measures)
	Social functions	• Organization of hospital social functions
Managerial instruments	• Financial management (hospitals intelligence on financial issues) • Marketing (e.g. client orientation) • Human resources (staff motivation, productivity) • Procurement (purchasing procedures for hospital equipment, medical and nonmedical supplies) • Business management strategy (long term strategies, how they are linked with performance of managers) • Clinical management strategy (quality-control reviews, clinical pathways)	

Source: Authors

In order to cover the main areas of the theoretical framework, a multi-method approach was employed. The research tools that were developed included survey questionnaires and topic guides for interviews with hospital managers and key health policy-makers. In order to perform country comparisons, questionnaires contained about 20 questions that were identical for Bulgaria and Estonia.

- Semi-structured questionnaires for representatives of managerial staff of hospitals (50 questions for Bulgaria, 51 questions for Estonia)
- Questionnaires for objective information – 11 questions about the type of the hospital (by profile of the activity, territorial coverage, etc.), legal status, infrastructure and human resources, revenues by main sources and expenditures by main types (for Bulgaria only)
- Topics guide for semi-structured interviews with key stake holders (20 questions for Bulgaria, 22-23 questions depending on the position of the interviewed for Estonia)
- Semi-structured questionnaires for representatives of supervisory boards (for Estonia only) (35 questions).

The main topics (sections) explored using different research methods (survey questionnaires and topic guides for hospital managers, supervisory boards' representatives and key health policy makers) covered the following issues:

- Health policy, hospital reform
- Legislation
- Efficiency
- Management and autonomy
- Ownership and management
- Access to health care
- Financing
- Human recourses

Hospital reforms: main developments

Bulgaria and Estonia had communist regimes until 1990, and since 1991 both countries are parliamentary democracies. The health care systems have been transformed from state-owned and controlled "Semashko" systems to decentralised systems financed through social health insurance and having public/private mix of services. At its initial stages, the emphasis of the health sector reform process has been on restructuring primary care and strengthening public health. The process of health care reform has been difficult, facing a number of challenges due to successive economic crises and political turbulence. The reforms have been introduced in the area of legislation, health financing and organisation as well as in the area of human resources. Over the past decade, in both countries decentralisation followed by re-centralisation of certain functions has been observed. The reforms were aimed at increasing efficiency, including strengthening of primary health care and restructuring inpatient care, while maintaining access and quality of services. In both countries the reorganisation of hospital care started as a second stage, after the reform in primary health care had advanced. Despite that some optimisation of the hospital care resources has been achieved, the process of improving hospital performance is facing significant political and managerial challenges.

Table 2. Selected country indicators.

	Bulgaria	*Estonia*	*EU*
Population	7. 72 million (2005)	1.34 million (2007)	500 million (EU27)
Average life expectancy	72.5 (2005)	73 (2005)	78.6 (2005)
Health care expenditures as % of GDP (2004)	4.7%	5.5%	9.27% (EU 15)
Hospital beds per 1000 population (2004)	613.13	581.79	649.61 (EU-25)
Average length of stay (acute care only)	10.6 (1996)	6.2 (2004)	
Occupancy rate (%) (acute care)	64.1 (1996)	68.4 (2004)	

The hospital sector in Bulgaria[4] and Estonia[5] has undergone a series of structural, regulatory and financial changes over the last decade of dramatic political and economic transition. Although hospital reform in Bulgaria has lagged behind the reform of primary health care, it has been intensified since 2000. The main reform steps are summarized in Box 1.

Box 1: The main developments in hospital reform

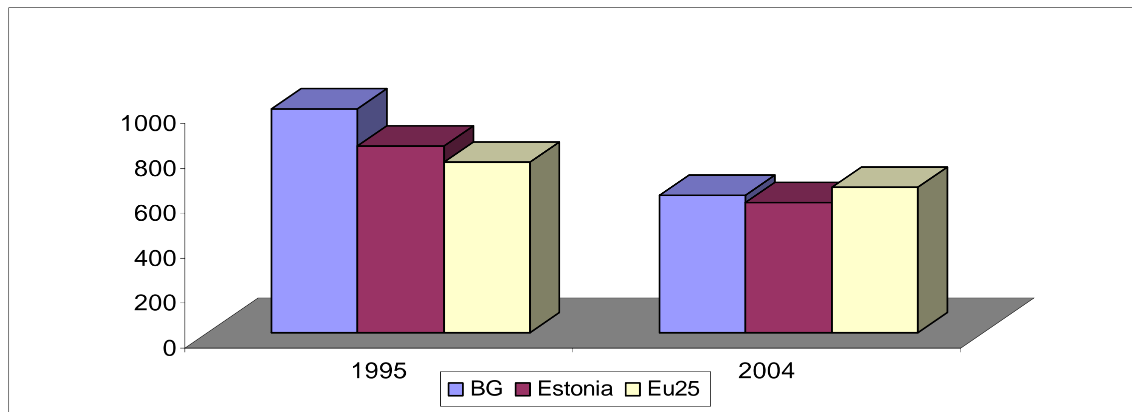
Bulgaria	**Estonia**
• Changing mode of financing of hospitals. Hospitals are financed from a mixture of social insurance via 'clinical pathways' (from 1999) and from the MoH budget (from 2004). Since 2006 hospitals are paid exclusively by the National Health Insurance Fund based on 'clinical pathways'. Capital expenditure is financed by the owner (municipality, state, private owner). • Introducing (competitive) contracting-out for pharmaceuticals, hospital foods etc. • Abolishing the 'regionalisation', i.e. providing patients with free choice of health care facility; and stimulating competition between facilities (from 2004) • Liberalisation of provision: creation of private hospitals • Introduction of accreditation procedure	•Purchaser-provider split (since 1992) and transparent contractual relationship between providers and insurance •Clearly defined legal status (joint stock company or foundation) and governance structure since 2001 •Seven types of hospitals with clear legal requirements. •Effective hospital's licensing system (first wave in 1994; second since 2001 when new Health Care Services Organization Act became effective) •Hospital Master Plan 2000, which sets long term development goals for hospital sector •Using EU Structural Funds for capital investments for acute care hospitals (since 2004)

Bulgaria has a much higher ratio of hospital beds to population than many countries in Europe. Bed numbers continued to increase during the first half of the 1990s, and peaked in 1996–1997 at 10.5 per 1000 population. They decreased again, amounting to 7.5 in 2000. In Estonia the number of inpatient beds per 1000 population has fallen from 9.62 in 1980 to 4.50 in 2002 (Figure 5). Since the licensing system was established, the number of hospitals and acute inpatient beds has continued to fall, mainly because many small hospitals providing predominantly long-term care lost their acute care status and were

[4] European Observatory on health systems and policies (2003), HIT summary: Bulgaria, WHO regional office for Europe, WHO. www.observatory.dk
[5] European Observatory on health systems and policies (2004), HIT summary: Estonia, WHO regional office for Europe, WHO. www.observatory.dk

turned into nursing homes. In recent years, reduction in the number of acute beds has been due to hospital mergers.

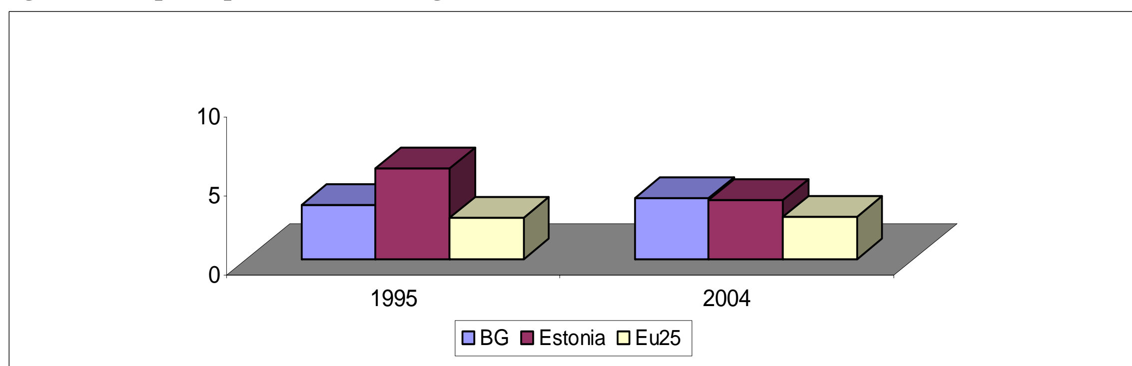
Figure 5: Hospital beds per 100 000 in Bulgaria, Estonia and the EU 25 in 1995 and 2004



Source: WHO, HFA database

Due to the extensive hospital network throughout Bulgaria, most people live in a reasonable proximity to some kind of inpatient care, although access is often obstructed by financial barriers. (Balabanova & McKee, 2002a/b) However, it is also the case that there is an excessive and often unnecessary use of beds, often for purposes of social care. The bed reductions in the latter half of the 1990s were the result of deliberate efforts of the government, which recognised the huge cost savings that could result from such measures. In Estonia, while the number of beds has fallen, the number of admissions per 100 populations has remained stable and the average length of stay has fallen by six days since 1992 and reached 6.9 days in 2002. In Bulgaria, the average length of stay (11.5 days in 2000) is still higher than in most countries in the WHO European Region, though it has been dropping steadily since 1980. The occupancy rate for Bulgarian hospitals (66.3% in 2000) is below European figures suggesting existence of various barriers for more effective care and utilisation. The occupancy rate in Estonia is in the same range (64.6% in 2002). In a decade (1995-2004) the number of hospitals dramatically decreased in Estonia. In Bulgaria the number of hospitals actually increased due to the legalisation of private hospitals (Figure 6).

Figure 6: Hospitals per 100 000 in Bulgaria, Estonia and the EU 25 in 1995 and 2004



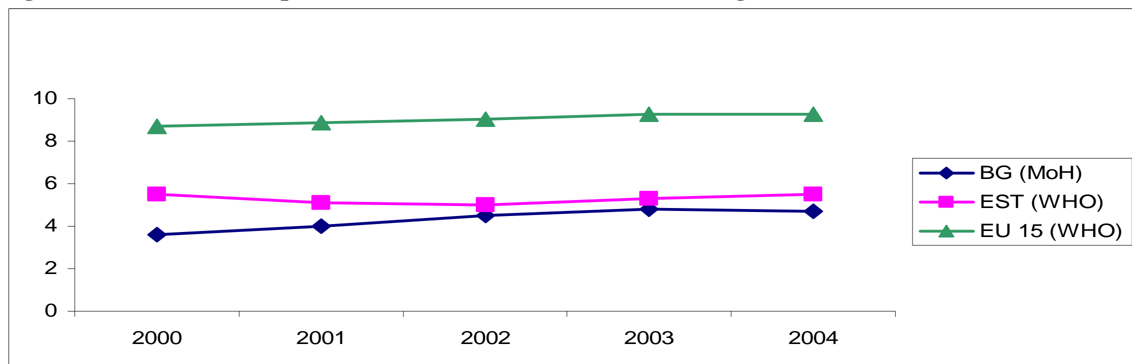
Source: WHO, HFA database

In Estonia inpatient acute care is provided by regional, central and general (or local) hospitals, as well as some specialist hospitals. In Bulgaria as well there are geographical levels: national, inter-regional and municipal as well as different types of hospitals depending on the type of care they provide (multi-profile and specialised). In the last 5 years, in the both countries the adopted legislation allows hospitals to operate under market environment, e.g.: as joint-stock companies or non-profit-making foundations (in Estonia) and as companies with limited liability (in Bulgaria). The major share holders (owners) are the Ministry of Health (Ministry of Social Affairs in Estonia) and/or municipalities in both countries. In the early 1990s some "parallel" public health systems providing health care to the police, railway workers, political elite and others have been abolished in Estonia and services were integrated into the national health system (with some small exceptions). However, this process was not undertaken in Bulgaria where "parallel" systems are still fully operational. In the two countries the existing private hospitals only focus on providing specialist services, such as gynecology, obstetrics, ophthalmology, etc.

Accreditation (licensing) procedure and certification have been introduced in the two countries. Yet the procedure is not performed by independent public agencies but the certificates are issued by divisions of the corresponding ministries (in Estonia – by Health Care Board, which operates under the Ministry of Social Affairs; in Bulgaria – by accreditation committees subordinated to the Ministry of Health).

Overall health expenditure as percentage of GDP in both countries is about 2-4 percentage points lower than those in EU countries, suggesting considerable underfinancing and shortfalls (Figure 7).

Figure 7: Total health expenditures as % of GDP in EU (15), Bulgaria and Estonia (2000-2004)



Inpatient care is financed though Health Insurance Funds which financed care on the basis of contracts signed with health care providers after negotiations. In Bulgaria the National Framework Contract is negotiated between the National Health Insurance Fund and the Bulgarian Medical Association on an annual basis and comprises a package of services, methods and levels of payment, and specifies conditions for providing the services, accounting rules and control. According to the Health Insurance Law (1998) once the two parties reach an agreement and sign the contract, the minister of health also has to sign the contract. If the contract is not signed due to a lack of agreement, the

provisions of the previous contract continue to be in force. This was the case in 2004 and in 2007. In Estonia, the negotiating parties – the Health Insurance Fund and the Hospital association[6] agree on the standard conditions (in force from 2003), which are effective for all hospitals. The list of hospitals eligible for long-term investment and contracts with the Health Insurance Fund EHIF is ratified by the government.

Prior to reform, payment for hospital services in Bulgaria and Estonia was based on historical budgets. The health care reform involved gradual introduction of new payment mechanisms allowing hospitals to be paid according to clinical activities performed, to replace the old “inefficient system” of fixed budgets based on historical data. Yet the adopted approaches differ to a certain degree. In Estonia the payment of inpatient care providers, specified in the contracts already mentioned above, is based on the volume and average cost of cases treated in each specialty. Payment is based on service prices set out in the price list, which is similar for all inpatient providers, e.g. all providers are paid the same prices and there is no adjustment for hospital characteristics such as teaching status. The price list of services was established at the beginning of the 1990s, based on the German health system but significantly adapted to the Estonian context. Currently, the price list contains about 1800 different items in total. Some prices are set on a fee-for-service basis, while others are complex prices for specific procedures. There is no system of bonus payments. The list of services and prices is updated at least once a year.

In 2004, a Diagnostic Related Groups (DRG) payment system for inpatient services has been introduced in Estonia.[7] In addition to its use as a payment mechanism, the DRG system was also introduced as a classification mechanism that allows an overview of hospital activity, benchmarking of providers and resource allocation, with the aim of increasing productivity based on cases rather than individual procedures. The DRG system is introduced gradually and therefore, it is used in combination with other payment methods already in place.

In Bulgaria, payment is based on diagnoses, generally grouped in so called “clinical pathways”. The clinical pathways have been defined on the basis of the most widespread cases of hospitalisation. Every year, the number of clinical pathways is gradually increasing. The National Health Insurance Fund pays a fixed price for each clinical pathway and does not engage in active purchasing. The price includes the costs of the medical activities defined in the different packages; auxiliary services provided to a patient during hospitalisation, up to two outpatient consultations after the patient’s discharge from the hospital, etc. The Fund does not pay for partial completion of the activities under a clinical pathway, or for re-hospitalisation with the same diagnosis within a specified period (different for each diagnosis). In the contracts with the Fund, the providers of inpatient care specify the maximum number of cases in each category of clinical pathways. The number of cases may be renegotiated, if necessary and the Fund reimburses up to 20% more than the maximum number of contracted cases per package

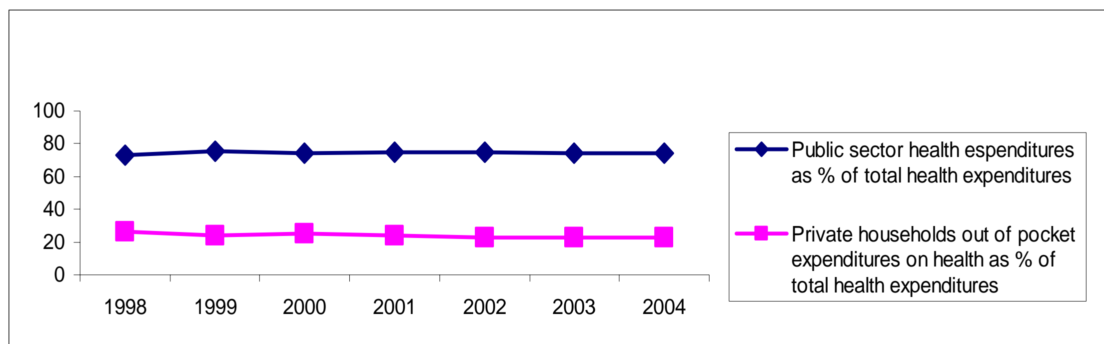
[6] which represents the hospitals outlined in the Hospital Master Plan 2015

[7] In 2001, the EHIF began work on adapting the Nordic DRG system (NordDRG) by identifying areas of variation in activity between Estonian and Scandinavian hospitals, calculating prices for reimbursement in Estonia and providing hospitals with feedback on their activity by NordDRG group.

but at a lower price than that agreed in the contract. For several years, work has been done to develop a DRGs system that would replace the clinical pathways in the country, but its introduction is still pending.

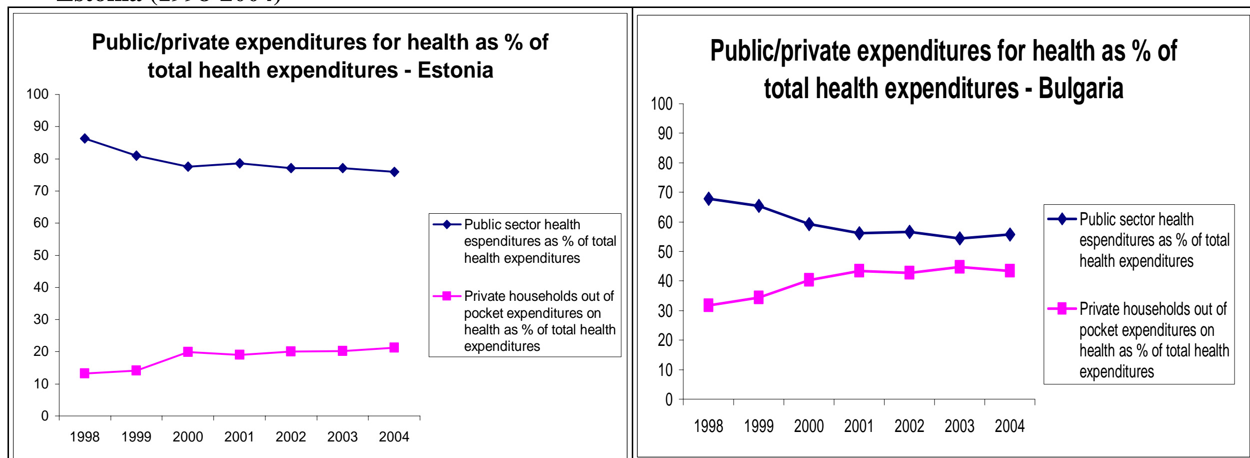
Hospitals in both countries also receive additional revenues from user fees, as well as from fees for services not covered by the insurance funds. In order to observe the trends and possible emerging inequalities associated with higher out-of-pocket payments, it is interesting to review figures for the share of public versus private health care expenditure in the EU (Figure 8), Bulgaria and Estonia (Figure 9). The figures clearly show that the share of private expenditures in Bulgaria is high compared to Estonia and the 25 EU Member states.

Figure 8: Public/private expenditures for health as % of total health expenditures - EU 25 Member States (1998-2004)



Source: WHO, HFA database

Figure 9: Public/private expenditures for health as % of total health expenditures – Bulgaria and Estonia (1998-2004)



Source: WHO, HFA database

Capital investment has been a problematic area in both countries. Prior to 2000, financing of capital costs was the responsibility of hospital owners – usually the state or the municipalities. However, as capital funding of hospital facilities competed with other claims on state and municipal budget spending, it was often deprioritised. Also, the allocations made in consecutive budgets were not sufficient, causing delays in or even

lack of investment projects. In Estonia, the problem of not having a systematic approach to capital investment was acknowledged by the government, and in 2000/2001 a new system for capital investment was established, e.g.: the investments should be the responsibility of the autonomous institutional providers, the insurance fund's price list should cover capital costs, a capital charge should balance the providers' different starting positions, and capital investment decisions in public hospitals need to be controlled. Thus, from July 2003, capital costs have been included in the prices paid to providers by the insurance fund.[8] However as capital cost funds are now allocated on the basis of activity, and there is no clear link to capital investment needs. In Bulgaria the costs for capital investments are theoretically the responsibility of the owners (e.g. the Ministry of Health/municipalities). Yet, due to the shortage of financial resources both on central and local levels, the issue of capital investments is neglected.

In the process of health system reforms in the two countries, a market environment for the hospitals has been created. Elements of competition among providers were introduced (in Estonia - 2003[9], in Bulgaria – 2004).

Study results

Study sample

In May 2006 a total of 83 personal questionnaires were posted to the members of the management boards in all 50 hospitals in Estonia. The overall number of returned filled questionnaires is 46, i.e. 55% return rate. Among the respondents 20 were heads of the management boards and 23 were management board members.

As described earlier, in Bulgaria both facility-level information and individual information on views and assessments of managerial practices and external environment (3 questionnaires for hospitals managers) were sent to all 207 state hospitals[10] The overall response rate for the factual (facility) questionnaire was 30% and for the full-length questionnaires - 26%. 26 semi structured key informant questionnaires were also conducted with a variety of stakeholders in hospital reform (Table 3).

[8] Capital costs have been added to the price list for ambulatory specialist visits, operations, provider per diems and complex prices. Capital costs have also been added to primary and long-term care prices. The mark-up has been calculated according to providers' optimal capacity per bed (which includes a standard number of square meters per bed that will produce an optimal occupancy rate).

[9] In Estonia, historical utilization data and needs assessment data are used to estimate potential patient movement, and the numbers are finalised at the end of the budgetary year. Providers can also agree to prices that are lower than those set out in the price list, enabling a degree of price competition.

[10] In 2005 in Bulgaria there were 262 hospital establishments - 125 multiprofile hospitals for acute care, 70 specialized hospitals (for acute and for long term care), 12 mental hospitals, 10 hospitals subordinated to institutions other than Ministry of health (MoH) such as the military, transport authorities, and 45 private inpatient establishments.

Table 3: Study sample: summary

ESTONIA	BULGARIA
Total number of hospitals	
50	262
Number of sent questionnaires	
83 personal questionnaires were posted to the members of the management boards in all 50 hospitals in Estonia.	One form for objective information for the hospital and 3 questionnaires for hospitals managers have been sent to 207 hospitals in Bulgaria (all hospitals except private ones and hospitals subordinated to the other than MoH authorities).
Number of returned postal questionnaires for hospital managers	
46 completed questionnaires (55% response rate)	161 completed questionnaires & 61 forms for factual information about hospitals (30% response rate)
Questionnaires for supervisory board members (Estonia only)	
13 completed questionnaires (33% response rate)	
Interviews with key policy-makers, including hospital directors	
9 respondents	26 respondents (18 with hospital directors and 8 with key stakeholders)

Health policy and legislation

Main stakeholders

There is a similarity between Bulgaria and Estonia with respect to the main stakeholders in the health policy field. The stakeholders exercise different degree of influence over the governance and management of hospitals (Table 4). A significant difference is the active role of the Hospital Association in Estonia. The Association is closely involved in negotiations and contacting process together with the insurance fund with respect to the package of services, payment methods, quality of care, control, etc. In Bulgaria a number of hospital associations exist but their role is relatively limited and they are still not acting as a key stakeholder in the hospital care.

Table 4: Key health care stakeholders in Bulgaria and Estonia

Bulgaria	Estonia
Parliamentary health committee	Parliamentary Committee on Social Issues
Ministry of health	Ministry of Social Affairs
Ministry of Finance	Ministry of Finance
National Health Insurance Fund	Estonian Health Insurance Fund[11]
Voluntary insurance funds	Municipalities
Bulgarian Medical Association[12]	County Governments
Hospital Association	Hospital Association
National drug agency	State Agency of Medicines

[11] In 2001, the EHIF obtained its present status as a public independent legal body, replacing the Central Sickness Fund and 17 regional sickness funds.
[12] Compulsory membership

Trade unions	Estonian Medical Association[13]
Municipalities	Estonia Nurses' Union
Hospital owners	
International ad donor organizations	
Citizens and patients organizations	
Suppliers of medical equipment and medicines	

The majority of hospital managers in both countries report having the most active interaction with the Health Insurance Funds. In Estonia, the collaboration with the Health Insurance Funds is followed by the Hospital Association – 60% and the Ministry of Social Affairs – 51%. In contrast, in Bulgaria, the communication with the Ministry of Health is also on a regular basis. Notwithstanding all existing linkages, a more explicit dialog and exchanges between stakeholders is seen as necessary.

Hospital reforms and legislation

In both countries hospital reform has intensified since 2000. Legislative frameworks adopted allowed implementation of organisational changes (Table 5). There have been at least two reasons why the legal systems of the CEE countries undergoing transformation had to be changed. First, the old norms did not conform to the new political principles accentuating a democratic decision-making process. Second, legal norms were required as a tool for reorganisation and introduction of new market-oriented mechanisms. This twofold change in the health sector legislation signified departure from the centralised 'Semashko' model (BASYS, 1998).

Table 5: Legislation related to hospital reform

Estonia	Bulgaria
• Public Health Act, 1995 • Medicinal Products Act, 1996 • Psychiatric Care Act, 1997 • Health Insurance Fund Act, 2001 • Health Services Organization Act, 2002 • Law of Obligations, 2002 • Health Insurance Act, 2002 • Commercial Code, 1995 • Foundations Act, 1995 • Public Procurement Act, 2000	• Law for Health Insurance, 1998 • Law for Physicians' & Dentists' Professional Associations, 1998 • Law for Health Care Facilities, 1999 • Law for Medicines and Pharmacies, 2000 • Law for Control Over Drug Substances, 1999 • Law for Transplantation of Organs, Tissues & Cells, 2003 • Law For Blood, Blood Donation & Transfusion, 2003 • Public Health Act, 2004 • Trade Law, 2002 • Public Procurement Act, 1999 • Labour Code, 1990 • Privatization Law • Competition Law • State Budget Act (annual) • National Framework Contract (annual)

[13] Voluntary membership

In Bulgaria, by 2005 there were already a number of laws addressing directly or indirectly hospital care, but only some of these aimed to facilitate specifically implementation of hospital reform. The most pertinent laws are the Law for Health Insurance and the Law for Health Care Facilities. Hospital facilities are also subject to general company legislation and other regulations outside the scope of the health system, as hospitals are commonly given the status of limited companies.

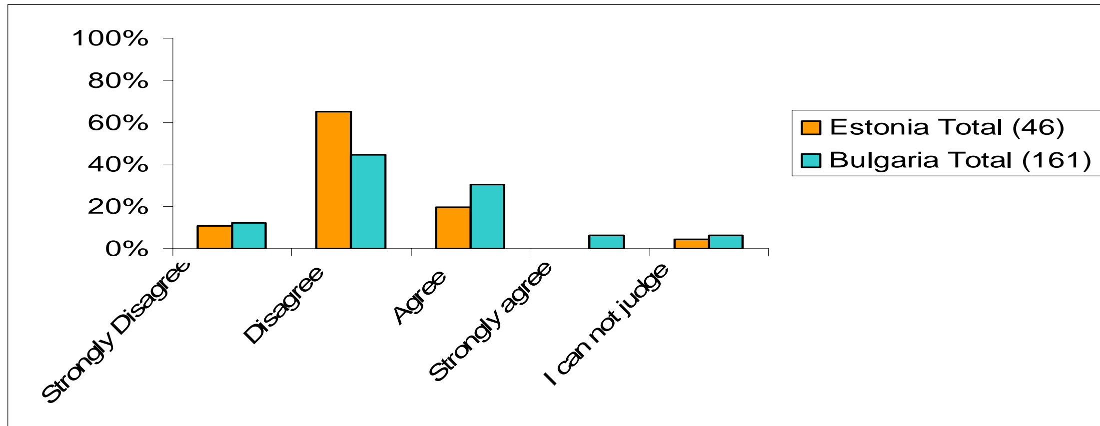
In Estonia, the Health Insurance Act of 1991 and the Health Services Organization Act of 1994 established a system of social health insurance based on multiple sickness funds and a purchaser–provider split. The parallel health systems of health care delivery were abolished (with the exception of primary care for the armed forces, and primary and some secondary care in prisons). This has not been the case in Bulgaria. A further reform involved changes in the legal status of the Estonian health care providers. The 1994 Health Services Organization Act had not specified provider status options, giving rise to some uncertainty about legal rights, responsibilities and accountability in relation to hospital management. The new version of the Act, which came into force in 2002, specified that health care providers would operate as private entities under the civil law, as limited liability joint-stock companies (for profit), foundations (not for profit) or private entrepreneurs (self-employed individuals). However, in the case of institutions, the founders or stock-owners are public, so the strategy can be more accurately described as one of "corporatisation" rather than privatisation. The aim of this strategy was to create efficiency incentives through increased decision rights at the hospital management level, while maintaining representation of the public interest through having the state and the municipalities appoint members of hospital supervisory boards.

In Estonia in 2000, the Ministry of Social Affairs has developed and adopted a Hospital Master Plan 2015 where projections about future hospital capacity have been made. The plan noted that Estonia's geographically decentralised hospital system resulted in excess capacity. In 1991, Estonia had about 120 hospitals with about 18 000 beds. Since then, the number of hospitals and the number of beds have fallen dramatically and by 1995, there were 83 hospitals with about 12 000 beds, and by 2001, there were only 67 hospitals with about 9100 beds. In 2002, many hospitals had merged, and by the beginning of 2003, the number of hospitals had fallen to no more than 40. The Hospital Master Plan 2015 recommends that the number of acute hospitals and beds be further reduced, to 21 acute hospitals and 2 acute beds per 1000 population respectives. In contrast, in Bulgaria a strategy for hospital restructuring has been discussed for over several years, with a draft made available for a public debate in 2006, but is still not adopted officially by the government. Some partial attempts were made to speed-up the restructuring process by changes in the hospitals financing mechanisms.

Interestingly, most hospital managers included in the survey in both countries were critical about the clarity and the existence of strategic objectives of hospital reform (Figure 10). Although Estonia has adopted a Master Plan for hospitals, a majority of the health facilities managers think that the state policy in the field of health care has not clearly defined strategic objectives in performing hospital reform. 76% have the opinion that the long-term objectives of the hospital reform are not clear and well defined enough.

In Bulgaria the majority of survey respondents also thought that the state health policy has no clear strategic objectives for hospital reform (disagree to certain extent 57%; agree 37%).

Figure 10: To what extent you agree with the statement that there are clear strategic objectives in state health policy, in relation to hospital reform?

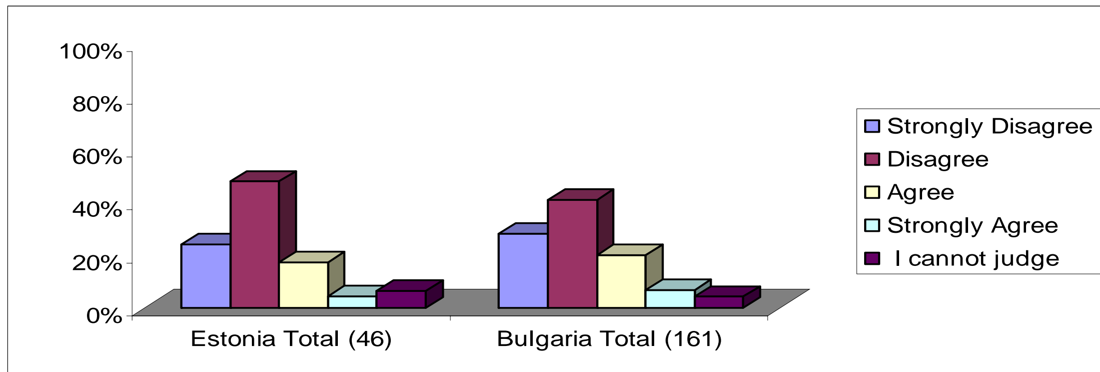


Indeed the higher the level of the respondent's position is, the better understanding of government intentions for hospital reform is observed. In Estonia, the heads of the management boards are more aware of the strategic objectives of national health care policy than the members of the management boards. Similarly, in Bulgaria, the heads of clinics/wards tend to have more negative views compared to the directors/managers.

There is small difference in perceptions of the Bulgarian managers of the smallest hospitals (district/municipal) and regional hospitals who have slightly higher negative attitude (53% and 57% respectively) toward state strategic objectives compared to the national hospitals (47%. In Estonia, the objectives of hospital reforms are least clear to Estonian managers of general hospitals compared to others. On average the objectives are more understandable for managers from foundation type hospitals than for limited companies (30% on managers from foundations, 6% from limited companies thought the objectives to be clear)

A significant majority of hospital managers in both countries feel that hospital care is not a priority in the government's health policy (Figure 11). In Estonia, 72% of responded admit that hospital sector is not the priority of national healthcare policy. In Bulgaria, the negative answers (69%) prevail over the positive ones (27%).

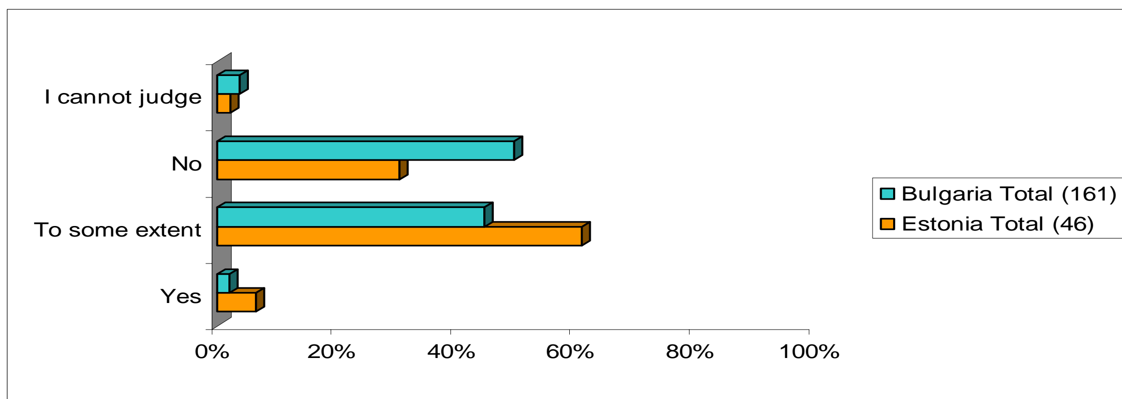
Figure 11: Would you agree that the hospital care is a priority within the government's health policy?



The central and regional hospitals' managers are the least likely to report that hospital sector reform is a priority for the Estonian health care policy. The managers from other hospitals agree more often with the statement that hospital sector is being prioritised. In Bulgaria again, heads of departments are less likely to report hospitals to be a priority compared to more senior management levels. Municipal district-based hospitals are also less convinced compared to national and regional hospitals.

When asked if they can influence the reform process, hospital managers are divided in their opinion (Figure 12). In Bulgaria only 2% think that they definitely can influence the reform process, while almost 45% think that they can have influence "to an extent"., and , in Estonia, majority of managers - 68% think that they can influence the formulation and implementation of hospital reforms (7% - definitely and 61% - to some extent). 30% of respondents in Estonia and 50% in Bulgaria believe that they have no influence over the reform process and content.

Figure 12: Do you think you personally can influence some aspects of hospital reform?



When looking at the responses by hospital type, they show quite a large diversity. Surprisingly, respondents from municipal hospitals in Bulgaria thought that they have more influence on health policy compared to respondents working at national and inter-regional ones, possibly because they have established strong, often informal contacts with the local community and regional policy-makers. In Estonia the managers of general,

central and regional hospitals are more confident in the fact that they can influence the hospital reforms. On the other hand managers from other hospitals i.e. from special, rehabilitation and long term care hospitals are relatively uncertain in their ability to influence reforms.

The hospital managers in Estonia pointed out that the main channels to influence the reforms are formal channels at national level and informal channels, personal contacts. Both of these were mentioned in nearly half of the (51% and 49% respectively) completed questionnaires. The managers from general hospital use more intensively personal and political channels than managers from other hospitals. The managers from limited companies use different channels more frequently, mostly informal and formal channels at national level. The members of the management boards play more political games, but head of the management boards try to influence the reforms at the regional level. In Bulgaria the mood is more pessimistic as 50% think that they have no means to influence the reform process, almost a third consider informal channels (personal contacts) as a possibility to exercise influence. Bulgarian managers tend to be more confident in their ability to make a difference in the reform process on regional level (29%) rather than on national level (9%). As expected, two-thirds of the directors think that they may have influence over the health policy reform process compared with just over a third of heads of clinics. Despite their higher-level position, 32% of the directors express the opinion that they cannot influence the reform. Younger managers (under 45) or those who have been at this position for less than five years are also significantly less likely to feel empowered to actively participate in the policy process.

The three most frequently noted positive steps in the process of Estonian health reform in the last decade were: the establishment of the health insurance system and health financing system, the elaboration of standards for hospital types and elaboration of long-term development plans. In Bulgaria changes in financing, improvements in hospital management and legislative framework were listed as the most important once (Table 6).

Table 6: Positive aspects of hospital reform in Estonia and Bulgaria

Estonia (last 10 years)		**Bulgaria (last 5 years)**
Hospital managers	*Supervisory board*	
Establishment of health insurance system (incl. contracting) and certain revenue base	Development of Hospital Master plan	Financing and accounting issues
Requirements for hospital types	Capital investments, renovation of buildings	Some improvement of hospital management
Development of Hospital Master plan	Optimization of hospital network	Some improvements of legislative framework

Free patient choice of a hospital was considered as another important aspect in the hospital reform process. In both countries the elaboration of standards and the implementation of procedures for licensing (Estonia) or accreditation (Bulgaria) were perceived as a positive development by the hospital management bodies. The new requirements encourage quality improvement and responsiveness of care and this is also considered as a step forward. The changes of the hospital financing mechanisms, e.g. the

introduction of social health insurance system and of a payment to providers based on performed activities have been also evaluated positively by the respondents in both countries.

The changes in the legislative and regulatory framework are commonly seen as positive achievements in both countries. However, in Bulgaria there was considerable criticism of the lack of consistency and even contradictions between some of the existing legislation. Similarly, in Estonia there are also a number of laws (the Accounting law and Pharmaceutical law) that do are not well harmonised with the general legislation and cause concerns for the managers. The opinion is divided on whether the legislative and regulatory framework is supportive enough for running the hospital. Many Estonian managers express the view that the legislative framework could be more supportive than it is currently. For example, the labour legislation, and specifically the frequently mentioned the Work- and Recreation law, which imposes unrealistic restrictions on staff working hours. According to the managers, there is a significant contradiction between civil law, entrepreneurship and public interest, services that are available, and the expectations of different stakeholders (population, health insurance fund, and municipalities).

However, the problem appears more acute in Bulgaria. Indeed, the Bulgarian respondents mainly mention the legislative framework in terms of its obstructive role to their work. The public health law is mentioned as one of the acts which has drawbacks and is not synchronised with other normative documents. The National Framework Contract is the most criticised document as it has to be renewed annually and there are always delays in negotiations. Labour code and collective contracts signed for particular branch of the economy (health care, education, etc.) required for different sectors are seen also as a challenge by the hospital managers in Bulgaria.

The regulation and changing of ownership of hospitals into corporate bodies are seen by some managers as affirmative changes. Yet, the Bulgarian managers argue that due to some legislation inconsistencies they are not able to manage their hospitals independently as autonomous bodies. Other differences occur between the perceptions of the Bulgarian and Estonian managers are with respect to the long-term development plans for hospitals. In Estonia, the elaboration of long-term development plans was emphasised as a positive side of the reform, and particularly the elaboration of the hospital Master Plan. Given that in Bulgaria no long-term planning document exists, the managers are critical to the lack of government vision on the development of hospital care in the country. The reduction of hospital capacity - consolidation (reorganisation and/or closure) of small and ineffective hospitals is considered by some Estonian managers to be a progressive step. In Bulgaria the lack of political will to undertake radical restructuring of hospital sector, or even to initiate debate around these issues is criticised.

Another major difference observed in the two countries is the perception of hospital managers of the existing situation with continuity of care. In Estonia the hospital sector managers indicate some positive movements with the formation of the General practitioners (GPs) system and reform of emergency care. In Bulgaria hospital managers

declare that the communication within the health care system is rather poor, continuity of care is often disrupted. The GPs are frequently seen as non-cooperative and not pursuing the patients' best interests. It seems that building integrated services - between primary care and hospitals - has been a problem to some extent in Estonia as well, but not as severe as in Bulgaria. The rapid decrease of bed days and treatment duration without prior preparation of ambulatory and social services has led to a "*weak link between the primary care and hospital*" and has been noted as one of the reasons for fragmentation of care. Regarding emergency care, severe coordination and financial problems are mentioned by the Bulgarian respondents.

It is interesting to observe that in both countries same aspects of hospital reform are listed as positive or as negative, with the latter being emphasised more strongly. Shortages in funding and resources as well as poor implementation of reform initiatives are common negative aspects for both countries (Table 7).

Table 7: Negative aspects of hospital reform in Estonia and Bulgaria

Estonia (last 10 years)		**Bulgaria (last 5 years)**
Hospital managers	*Supervisory board*	
Health financing system, incl. shortage of resources	Poor implementation of Hospital Master plan	Insufficient funding of hospitals
No clear agreement on long-term objectives in hospital sector	No clear agreement on long-term objectives in hospital sector	Multiple aspects of hospital reform
Closure of hospitals/departments	Hospitals acting under private law	Imperfect legislative and administrative framework

The respondents in the two countries have been critical with respect to the instability and lack of clarity in hospital reforms and objectives, politicisation, monopolisation (existence of monopolistic structures such as the National Insurance Funds, etc.), insufficient attention on long term care, altered ownership relations. The main problems in the financing, resource allocation and cost management seem to be the underfinancing and instable financing of the health care sector – the gap between the expectations and possibilities and the unclear financial responsibilities (namely the issue with the lack of responsibility for capital costs and investments).

Expressions like "*the objectives of the reform are not clearly formulated*" and "*the absence of an agreement between different political parties in reorganizing and financing of the health care system, and absence of clear perspectives*" can be found in the respondents' answers in both countries. On the negative side, hospital reforms seems to have deprioritised long term care, e.g. lack of planning for long term care beds and lack of resources for this type of care. Another emerging issue in Estonia and Bulgaria is that "*the hospitals have turned into the commercial organisations*", while on the other hand the liberalisation of the hospital sector and introducing some market principles such as competition is perceived to be a positive step. Clearly, most reform initiatives are not assessed as positive or negative per se, but preserving the balance (e.g. between market and social function) is seen as important.

Initiatives involving training personnel and encouraging improvement of their qualification were mentioned as positive steps taken by the stakeholders to improve hospital efficiency. However, respondents in both countries are very vocal in their concerns regarding the lack of qualified staff at places. Other human resources-related problems are staff dissatisfaction with wages, work conditions and opportunities that are the reasons for doctors and nurses to leave the profession. Lack of consistent government policy on human resources is heavily criticised by the hospital managers.

Overall, in both countries hospital managers participating in the survey mentioned that hospital reforms tend to be inconsistent, slow, and poorly implemented, with little monitoring and learning. There is a fear of changes due to changes in political power, politicisation of institutions seeking to interfere with hospital management (e.g. supervisory boards) and the poor capacity at the state institutions, e.g. the ministries of health. All these factors may cause misuse or inefficient use of scarce resources and create confusion among managers and front-line practitioners about the long term perspectives for development.

Resources and management

Financing

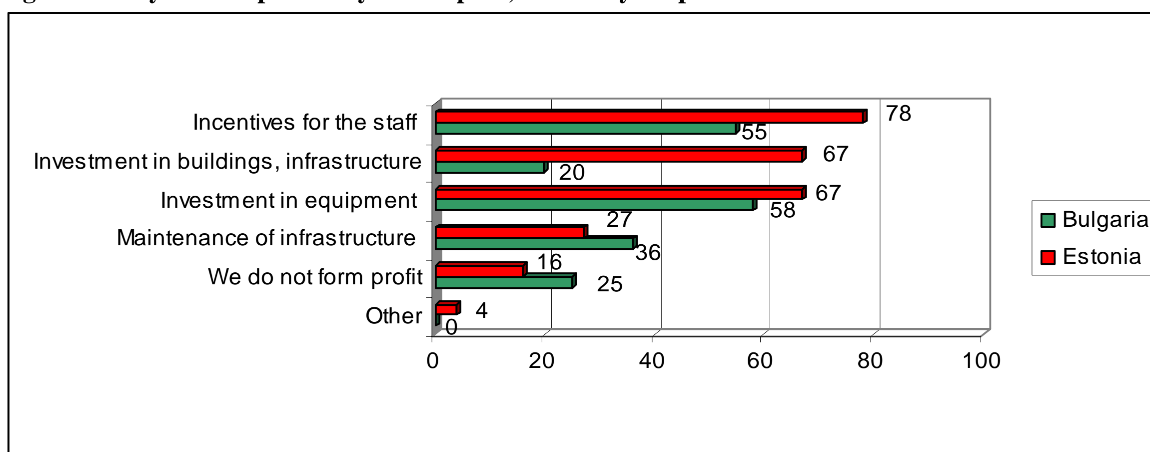
The mode of financing and appropriate level of resources are crucial for the successful work of hospitals which are dependent on expensive equipment and infrastructure. In both countries hospitals suffer from insufficient financing. In Bulgaria majority of hospitals have accumulated huge debts over several years. Asked "Who has to bear the responsibility for the losses (depths) of hospitals?" the respondents in the two countries share almost the same view that it is the management board that has to bear the main responsibility for the losses and debts of hospitals. (Table 8). Surprisingly, the owners (the Ministry of Health - in the case of Bulgaria) come second, followed by the national health insurance funds. In Estonia, Ministry of Social Affairs, Ministry of Finance (state budget) and municipalities were also mentioned but not as frequently as the first three responses. In Bulgaria some respondents also refer mostly to the need for a state subsidy via the state budget.

Table 8: Who should take the main responsibility for the losses (debts) of hospitals?

Estonia	Bulgaria
Management board	Hospitals themselves /management board
Owners	Ministry of Health
Estonian Health Insurance Fund	National Health Insurance Fund

Although most hospitals do not form profit, according to respondents, when they do have a profit, they spend it to stimulate the staff, to invest in equipment and infrastructure (Figure 13). Maintenance of infrastructure was less frequent in Estonia, but more often the case in Bulgaria. In Estonia, investment in infrastructure is more frequent.

Figure 13: If you have profit in your hospital, what do you spend it on?



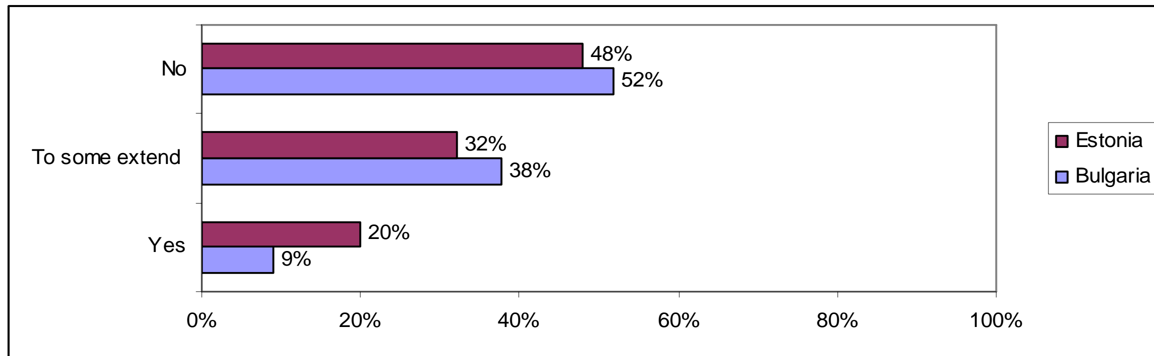
In order to estimate the level of autonomy our team has asked the respondents about the approaches they apply with respect to the internal management of finds. There are significant differences in the results for the two countries (Table 9). In Estonia, the costs are being allocated to departments mostly according to planned activities (66%). Other approaches include allocation of funds based on historical costs (from previous years), according to performed activity, etc. In Bulgaria, the most frequently used approach is allocation based on actual volume of work (81%). Yet, for a significant number of respondents the methodology of allocation is not clear. There were mixed view on the necessity to cross-subsidies departments that do not form profit (or surplus) but are vital for the hospital as a whole (e.g. pathology).

Table 9: Allocation of funds between clinics/wards

	Bulgaria	Estonia
Based on actual volume of work	81%	39%
Not known/ not clear	10%	14%
Based on the costs in previous years	4%	43%
Other	3%	5%
Based on planned activities	2%	66%
No specific criteria	-	14%

It is not very common for the clinics and wards to manage independently the allocated funds. About a half of the respondents (48% in Estonia and 52% in Bulgaria) in both countries declare that clinics and wards have no financial autonomy (Figure 14). About a third claimed that there is some autonomy ("to some extent"). In Estonia the percentage of those who perceive autonomy of wards and clinics is twice as high (20%) as in Bulgaria (9%).

Figure 14: **Do the clinics/wards govern the allocated funds by themselves?**



Human resources

The motivation of staff and good remuneration are important factors for achieving good quality of care and effectiveness of work. The results of our study show that there is a link between remuneration and performed work. In Estonia, 76% of respondents report to have different pay grades for different positions in their hospital. This is much more the case for medical and high level administrative staff in comparison with the technical staff at lower levels for both countries. According to the respondents the remuneration of physicians is mostly linked with the performed work (Table 10).

Table 10: Linkage between remuneration and performed work

	Bulgaria	Estonia
For physicians	76%	52%
For nurses and other medical staff	72%	48%
For administrative staff	62%	22%*

*excluding management board

In central and regional Estonian hospitals there are pay grades for different position in every hospital included in the survey. In the other hospitals two-thirds of respondents reported to have implemented the pay grades. Indeed, the performance related payment is quite widespread among hospitals.

In Bulgaria, payment of staff has been increasingly linked with their activities and there are some fluctuations (decrease in real terms) of the level of salaries in the last year caused by the introduced changes. Overall, the low level of salaries in the health care sector in Bulgaria is expected to drive a number of medical staff and particularly nurses from their jobs and promote migration to the EU. However, the current study showed that there is very little change over a 5-year period (2000-2005) despite active reform and acute underfinancing. Another human resources problem is the aging of staff - the average age of hospital staff in the Bulgarian hospitals participated in the study is 45.4 at the end of 2005 and among physicians only, the average age is even higher – 46.7 years.

In Estonia and in Bulgaria, hospitals have plans for further training of the staff. In Estonia, 73% of respondents stated that in their hospital there are written plans and staff

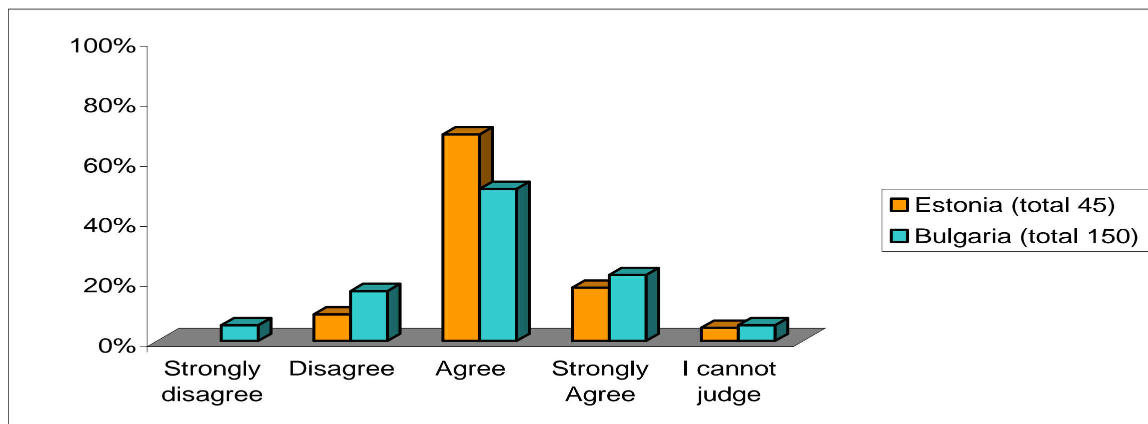
is being set objectives for clinical training. In management training the number is not as high – one third of the respondents reported that there are objectives and plans for management training. The plans and objectives are also in other areas as: training in food management, in communication skills, in IT, in customer service; training for technical personnel and mid and junior medical personnel. In Bulgaria, 75% of respondents stated that there are plans for training in clinical skills, 16% pointed out that training in managerial skills is foreseen and 9% that some other type of training is planned.

Personal communication together with regular clinical meetings in each department were revealed as the most important channels for internal communication among hospital staff. However other channels such as the Intranet gained importance while staff newsletters (bulletins) were seen as the least important source of information (in Estonia).

Management

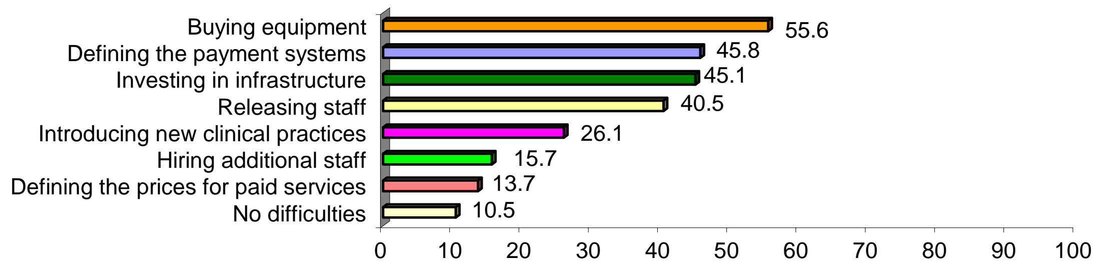
In both countries a majority of the hospital managers have expressed agreement with the fact that management boards have sufficient autonomy to manage their hospitals. According to the opinions expressed in the survey, in Estonia the possibilities to manage health establishment in an autonomous way are more pronounced than in Bulgaria (Figure 15).

Figure 15: Do you agree that the management council (board) of your hospital has sufficient autonomy to manage the hospital?



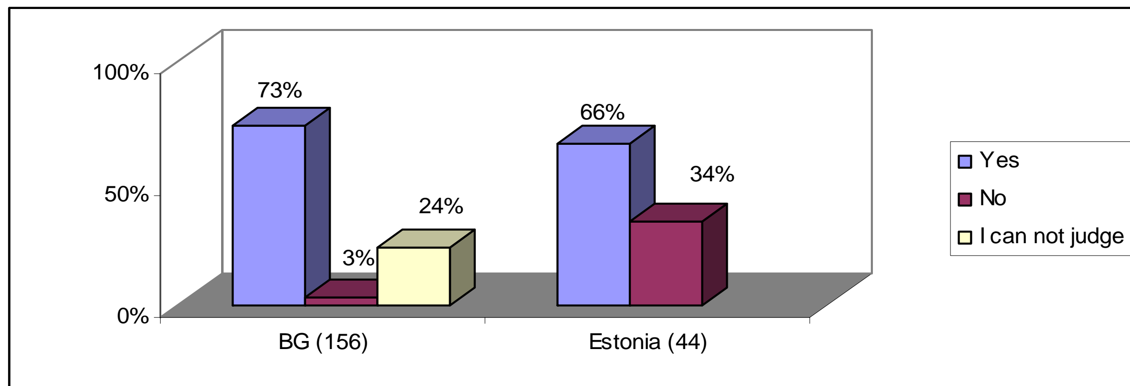
Among the hospitals in the Bulgarian sample, only in 8.5% there was a supervisory board. According to the Bulgarian managers, the most important functions of the management board are: planning, taking decisions for and control over the activities as well as financial management. Yet, the managers are faced with a number of difficulties when making autonomous decisions in managing their hospitals (Figure 16). However, significant variations are observed when analysing the answers of the respondents across different types of hospitals: larger/national hospitals are less autonomous in investing in equipment and infrastructure, but more autonomous in deciding on prices for paid services and mechanisms for provider payment.

Figure 16: Difficulties to take decisions on hospital level (Bulgaria)



The majority of hospitals in Estonia (66%) and in Bulgaria (73%) have some kind of business plan or investment strategy with respect to capital assets and medical equipment (Figure 17). In Estonia, it is mandatory for hospitals to have a general development plan. In Bulgaria, the established accreditation procedure have gradually set requirements for the hospitals to prepare business plans and strategies. Yet, 24% of the Bulgarian respondents declare that they do not know about such documents.

Figure 17: Does your hospital have a business plan or investment strategy with respect to long-term assets and medical equipment?



The conditions of the infrastructure and equipment in the hospitals were also important. Overall, the Estonian managers were more critical than the Bulgarian regarding the conditions of the infrastructure and the medical equipment in their facilities (Figure 18; Figure 19).

Figure 18: What is the general condition of the infrastructure (buildings) of your hospital?

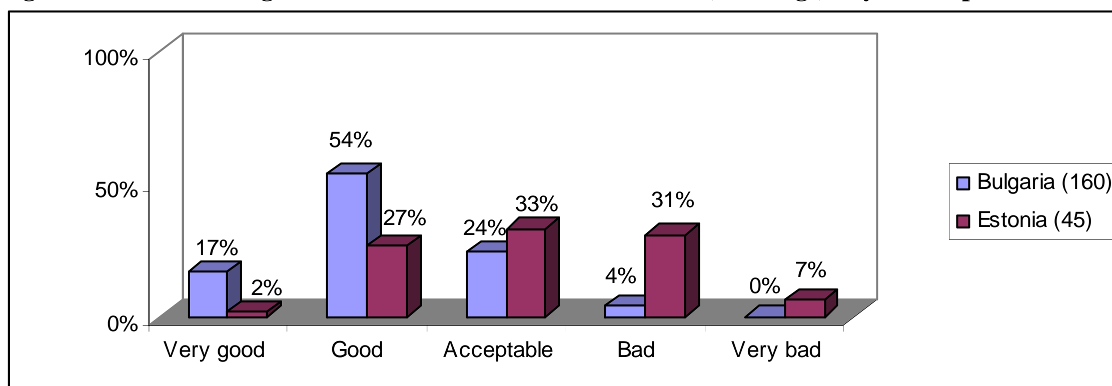
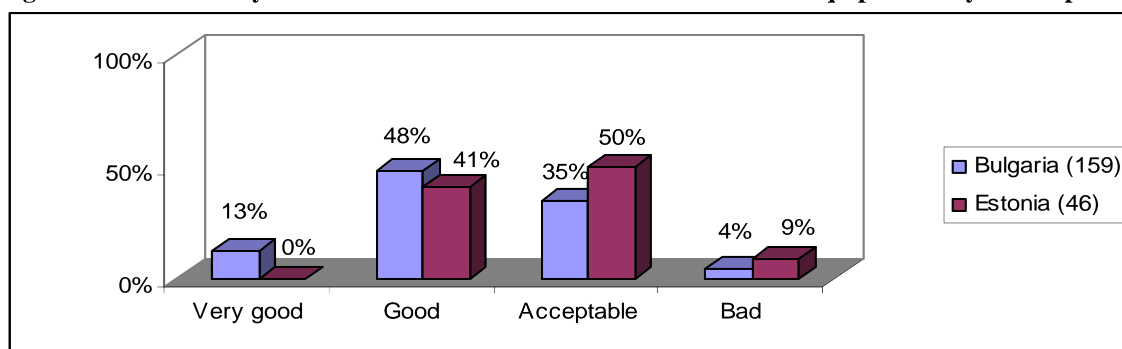


Figure 19: How could you estimate the overall condition of the medical equipment in your hospital?



Most hospitals have also documents stating vision and mission of their facility and strategy for development. However, in Bulgaria about 30% of respondents stated that these documents are not publicly available. According to the respondents, almost all of the hospitals have also documents related to quality improvement and encouragement of good medical practice (Table 11).

Table 11: Existence of documents regarding vision, mission and long term development of hospitals

In your hospital, do you have:						
	a written document stating its vision and mission?		a long-term strategy for its development?		have written document/standards for improving quality of care and encouraging good medical practice?	
	Estonia (43)	Bulgaria (155)	Estonia (44)	Bulgaria (156)	Estonia (45)	Bulgaria (153)
Yes it is publicly available	79%	65%	80%	44%	82%	57%
it is not publicly available		23%		37%		36%
No	21%	2%	18%	5%	18%	2%
I cannot judge		10%	2%	14%		5%
						% of the total

In the documents describing mission, vision and development strategies hospital managers define the internal aims to be achieved in the health care facilities. The review of the answers show that the objectives of Bulgarian and Estonian hospital managers are very much the same – quality improvement, efficiency, customers' satisfaction, etc (Table 12).

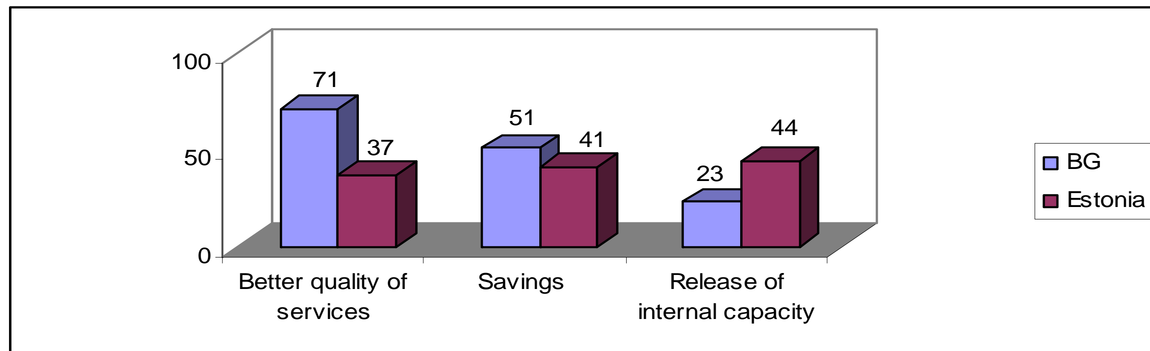
Table 12: Internal hospital aims, ranked by importance

	Estonia	Bulgaria
1	Quality improvement of medical services	Quality improvement of medical services
2	Improving client services	Improving efficiency
3	Improving efficiency	Transformation of the hospital into a centre of excellence

In order to achieve efficiency most of the hospitals in the two countries contract out some services to external providers. The three main services marked to be outsourced in Estonia are: the laboratory tests, pharmaceuticals and radiology. In Bulgaria those are: maintenance of medical equipment, laundry, laboratory tests and food. Some the other services mentioned by respondents in both countries were services for transportation and maintenance of transport vehicles, maintenance of buildings, construction and reparation, security services, outdoor cleaning and waste management, PR-consultations, consultations of specialists, specific analyses, pathology, etc.

The main reasons for outsourcing are achieving better quality of services, release of internal capacity and the saving of funds (Figure 20).

Figure 20: Reasons to outsource



There were also other reasons pointed out by respondents, e.g. historical relationships or legislative requirements (in Bulgaria), economies of scale and the higher manufacturing cost (in Estonia), etc. The main aim of outsourcing is to allow hospital staff to focus on the main activity and providing more flexibility for the management body.

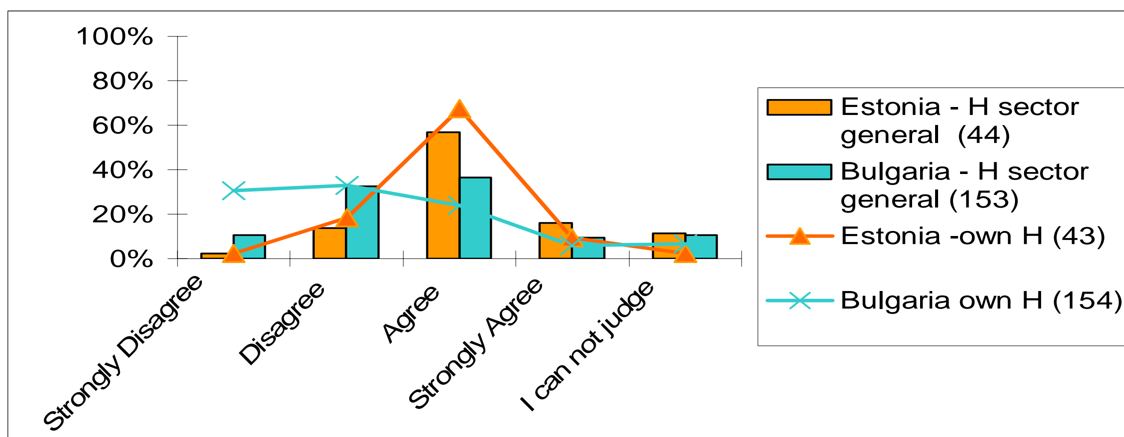
As already mentioned the survey on the role of supervisory boards had been performed for Estonia only. Overall, the supervisory board has strong influence in decision making process in hospitals. The least influential are the supervisory boards in opinion of managers in the general hospitals. More than half of the managers disagree with the statement that the supervisory board has strong influence on decision making process in

your hospital. The supervisory boards seem to have more influence on decision making process in limited companies. But, 69% of supervisory board members find that supervisory board should have bigger role. The supervisory board is on a large scale involved in the elaboration of the long-term strategy of the hospitals – 77% of respondents admit to have the involvement of supervisory board in the process. 85% of the responded managers report that their management board gives feedback to supervisory boards on the implementation of t he long-term strategy of the hospital. The feedback to supervisory boards is not given by management boards in opinion of the 10% of managers.

Efficiency

In Estonia managers think that in the hospital sector it is possible to use resources more efficiently. 73% of respondents believe in the possibility of increasing the efficiency of hospital sector. The least agree with the statement that in hospital sector in general is possible to use resources more efficiently the managers from other hospitals (63%). However those managers more frequently abstained from answering. 26% could not judge whether there are ways to use resources more efficiently. Managers from central and regional hospitals were more than other managers not in opinion that the hospitals in general could utilize more effectively their resources – 23% strongly disagree or disagree with the statement posed in the questionnaire. In Bulgaria 53% of the directors, 30% of deputy directors and 46% of head of clinics think that resources in hospital sector are used inefficiently and there is space for improvement. However, when asked about their own hospitals managers the opinion in the two countries is rather different. In Bulgaria managers seem to be much less critical about their own hospital compared to the hospital sector in general. In Estonia managers seem to be rather critical regarding the performance of their own health facilities - 77% of respondents agree or strongly agree with the statement that in their hospital is possible to use resources more efficiently. The managers from central and regional hospitals are more optimistic (85%) than average (Figure 21).

Figure 21: To what extent you agree with the statement that in hospital sector generally, and in your hospital, the resources are used inefficiently?



Increasing control over costs and performed activities is perceived as a necessary measure to improve efficiency in both countries (ranked on first place in Estonia and on 3rd place in Bulgaria) (Table 13). Optimizing clinical pathways is another tool for improving efficiency in the opinion of the managers, although the understanding of clinical pathways has different meaning in Bulgaria and Estonia. Moreover, the hospitals in Bulgaria are financed based on clinical pathways and the managers are keen to receive full prices of a clinical pathway and not partial reimbursement. Most common understanding might be considered in the formulation "optimizing clinical pathways" when discussion application of new approaches toward care and clinical practices.

Table 13: What in your opinion can increase the efficiency in your hospital?

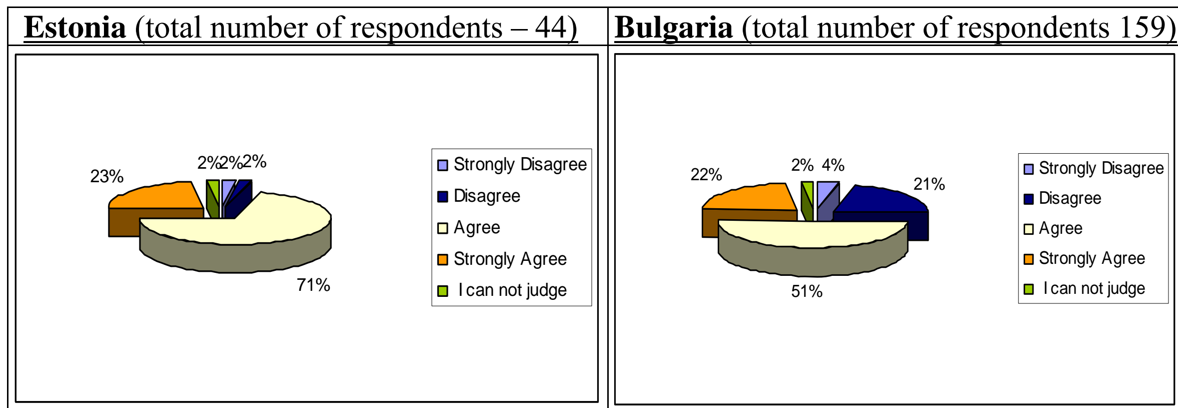
Estonia	Bulgaria
Increase of the control over costs and performed activities	Optimizing the clinical pathways, incl. real costing
Optimizing the clinical pathways	Implementation of new clinical practices (day care, home care...)
Other (better co-operation with other providers, staff restructuring)	Increase of the control over costs and performed activities

In addition both in Bulgaria and Estonia the optimizing the number of staff and beds and optimizing the drug supply is seen as an important measure to improve efficiency. In Bulgaria restructuring, renovation of buildings and equipment as well as introduction of public supervisory boards are also seen as a necessary steps. Indeed in Estonia there are supervisory boards and in this case the attention is to improve their efficiency in order to increase overall efficiency of hospitals. Other common issues emphasized by the hospital managers in the two countries is the improvement of the co-operation with other providers and assuring continuity of care and the integration of different services (primary, long term and social care). In Estonia, increasing the revenues and the volume of chargeable services is also seen as a possibility to increase efficiency and with regard to the human resources - redistributing the roles and reviewing the labor organization of nurses and by increasing the responsibility of persons (personnel).

Competition

In Estonia 94% of the respondents agree or strongly agree with the statement that there is competition in hospital sector. In Bulgaria this percentage is slightly lower - 73%. Yet in the negative answers in Bulgaria 25% think that there is no competition in the hospital sector compared to 4-5% in Estonia (Figure 22).

Figure 22: Do you agree that there is competition in the hospital sector?



This means that Estonian hospital managers perceive the environment in which they are working as more open for competition between the health care facilities than their Bulgarian colleagues. When measuring in a scale from 1 (lowest) to 10 (highest) how competitive the hospitals are in the two countries, the results from the survey show very small difference in the perceptions. Hospital managers in both countries rank the competitiveness of theirs hospitals in the range between 6 and 7 (for Estonia the mean number is 6.8, for Bulgaria - 6.6).

In Estonia, the managers from central and regional hospitals rate their hospitals' competitiveness higher (average 7,4) than managers from general and other hospitals where the average rating is respectively 6,8 and 6,4. The competitiveness ratings are quite similar for foundation and limited company types. The head of the management boards give lower ratings than the members of management boards. In Bulgaria the average evaluation of the competitiveness of hospitals in the sample is 6.6 (ranked on a scale of 0 to 10) as the highest is for national and interregional hospitals – 7.5 and the lowest is for municipal hospitals 6. The competition is considered to be useful as it is a means towards quality improvement and implementation of effectiveness measures. However, some hospital managers express doubts regarding the existence of competitive environment. It is considered that consumers are economically weak to make their free choice and they "*use the closest available hospitals, which means that there is no real competition*".

Responsiveness and quality of care

Access to care

Responsiveness of care, access and quality are the most important issues for the society regarding the provision of health care and in particular with respect to hospital care. In both countries hospital managers list a number of problems patients are faced with in order to receive hospital care (Table 14). In both countries the high number of emergency cases, which in some occasions is the fastest way to enter the hospital has been emphasized. Yet, admission as an emergency case means that the treatment has been significantly delayed and may cause much higher costs for the health establishment to treat the case.

Table 14: What are the problems the patients faced when seeking hospital care?

	Estonia	Bulgaria
1	Waiting lists for admission or treatment	Many patients have no health insurance
2	High external costs (for instance costs on transportation)	Insufficient number of referrals available to PHC staff/ GPs
3	The GP-s do not refer patient in time	Lack of timely & appropriate referrals

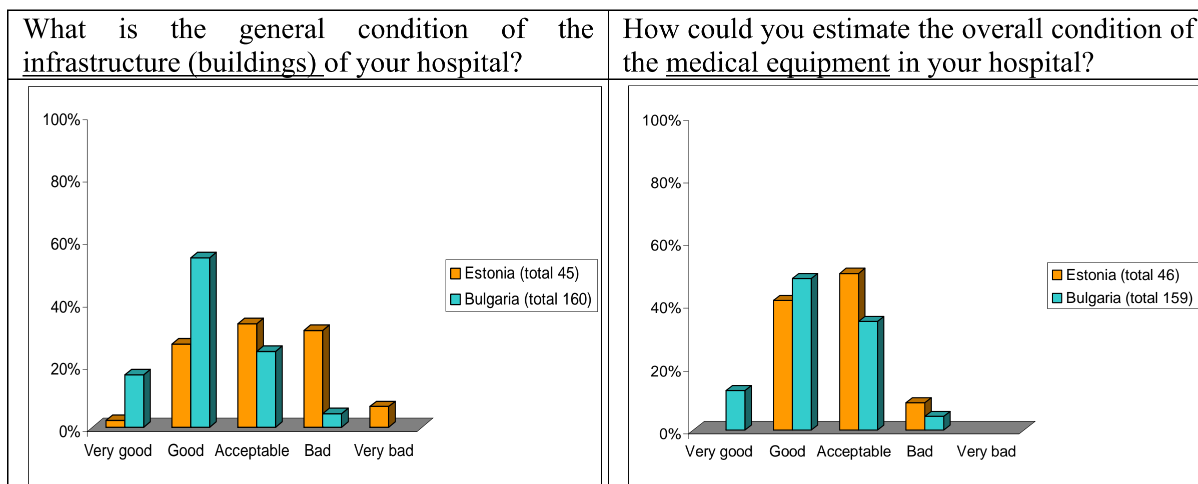
In Estonia, 80% of the respondents indicated as the biggest problems the patients have to face in order to receive hospital car are in opinion of managers the waiting lists for admission or treatment. The following were the high external costs mentioned and the GP-s do not refer patients in time. Furthermore on respondent indicated that the problem in long term care is the fees for bed days in chargeable beds and that the pension should be in accordance with the cost of hospital bed in long term care. The other problems listed by the hospital managers are the following: the large proportion of the emergency care; not enough health insurance resources and reserves; low prices; increasing shortage of doctors; patient awareness; short medical treatments after illnesses; the common people do not have sufficient information about the possibilities; the capacity by specialty.

In Bulgaria the main problems for access to care, in the perceptions of hospital managers are related to the high number of insured patients, delay in obtaining referrals, additional coats for transport (far location of specialized hospitals), additional costs for consumables and medicines (covered by patients). Waiting lists in Bulgaria are not ranked so high in the list of challenges as it is in Estonia. Although 67% of Bulgarian respondents report no payment is necessary in their health facilities, additional payments which patients have to make for consumables (18%), tests (9%), drugs (8%), other informal (4%), other formal (4%) is considered as a problem even from the hospital managers.

Quality of care

Provision of care on the highest possible level is an objective for any health establishment. Quality of care is one of the important factors for high competitiveness. The provision of high quality of services depends to a large extent on the conditions in the hospitals – general infrastructure and equipment supply. Overall, the hospital managers in both countries responded that the general condition of their buildings and equipment is good and/or acceptable (Figure 23).

Figure 23: Condition of infrastructure and equipment in the hospitals participated in the survey



The procedures for licensing (accreditation) are tools implemented in hospitals in Estonia and Bulgaria to assure good high level of quality of the provided care. In this respect hospital managers started to use surveys and questionnaires as feedback from patients in order to implement changes and to improve quality. Complaint procedures are gradually established on the level of health facilities as a way to observe quality and problems in the health facilities. International quality standards have been applied and government requirements imposed regular update of these standards to be performed by the management bodies.

Continuity of care

The results of the survey in the two countries show the existence of some problems with respect to the continuity of care. The severity of problem is different for Estonia and Bulgaria. However, it is important to emphasize that both countries suffer from insufficient collaboration between the different levels of care – primary, secondary, tertiary. Indeed, respondents report to have collaboration with specialists in outpatient care in order to assure the continuity of care. Problems are experienced in this communication which in some cases is no sufficient. There is perception among hospital managers in the two countries that general practitioners refer patients to hospitals with some delays. Other problem expressed by the respondents is the insufficient (or even lack) number of long term care facilities. Thus the continuity of care is abrupt as hospitals have to discharges patients who then have no place to go for further long term care. The mode of financing hospitals (in Bulgaria) does not stimulate establishment of long term care facilities as the purchasers for not pay the clinical pats for this type of care.

Challenges for hospital management

Problems

We have grouped the main problems that the managers have listed as they are facing in their daily work in several subgroups: organizational, legislative, financial, human

resources, other (Table 15). The most severe problems are associated with the human and financial resources. These problems were pointed by majority of respondents in both countries.

Table 15: Main problems for hospital management

	Estonia	Bulgaria
Organizational	people are lacking interest (inactivity) and responsibility	red tape, bureaucracy and difficulties in reporting & administration
	bureaucracy	complex procedures and difficult communication between institutions
	the progress is taken place only in bigger centers	poor linkages with primary care
Legislative	the law of labor- and recreation time (too restrictive in terms of working hours)	lack of coherent long-term legislation
	the constantly changing legislation	contradictory and uncoordinated regulatory and legislative acts
	the law on procurement	lack of clear strategy - balancing market mechanisms and social functions
Financial	low prices paid by EHIF	poorly financed clinical pathways
	low contract volumes	disparities between university/ national and regional hospitals
	underfinancing of capital costs	chronic lack of funds for consumables, equipment, capital investments
Human resources	shortage of educated and qualified personnel	lack of qualified staff - problem for small hospitals
	the quality of staff	poor motivation, problems with staff specialization and qualification
	ageing of staff	high workload (staff works in public and private sector)
Other	personal communication problems	increasingly negative attitudes of patients and society towards doctors
	insufficient competence in the management	cases of personal conflicts and poor relationships within hospital teams
	small hospitals are less important	poor capacity of the owner /municipal council/ and the health care committee

Other issues raised by the respondents refer to highly politicized hospital governance. This is emphasized by Estonian respondents particularly with respect to supervisory board level. The frequent political and health policy changes and lack of clarity leads to uncertainty among managers which affects every daily work and influences rapidly staff motivation.

Policy options for further reform

The project team made an effort to reflect the international developments[14] and experience of other countries[15] in the process of hospital reform in order to list some possible options for further reforms in Estonia and Bulgaria. By all means the stakeholders' actions toward further reform of hospital care should correspond with the main goals of health systems: efficiency, quality, solidarity and equity. Furthermore, enhanced coordination and stronger coordination between stakeholders should be encouraged.

Although, the model of governance may be different (decentralization versus centralization) the responsibilities of different stakeholders have to be made clearer. If the policy is directed toward giving a higher degree of freedom of hospitals, the policy makers have to assure strong monitoring and bench marking process to take place. In principal autonomous hospitals have: obligations stipulated in annual contract, more flexible planning, easier access to additional financing, possibility to finance investments and development projects by loans, more flexible staff policy and incentive systems, and increased decision rights over inputs and processes in health care delivery (e.g. better responsiveness to local needs and condition; incentives to increase efficiency; flexibility to do needed changes quickly; increased accountability and responsibility for outcomes, not just for following the rules). However the balance between steering and autonomy is usually unstable because hospital structures remain high political issue, e.g. closure and mergers of hospitals is very sensitive issue in the society. On one hand the capacity of Ministries of health to steer the process (when higher autonomy is established) is not always at high level which sometimes causes tensions between management and political logic. On the other hand, in the case of government (public) ownership politicians at central and mainly at local level have stronger incentives to be engaged with the hospital care issues.

We have observed many similar problems and challenges in both countries. The hospital policy in future has to be directed toward a number of critical issues, raised by the respondents. Quite a few actions may be applied in both countries. Indeed there are also some specific issues to be tackled by health policy makers in accordance with the particular country context (Table 16).

Further actions, common for both countries:

- Improvement of continuity of care (links between GPs/outpatient specialists/emergency care/other hospitals). Optimizing referrals;
- Clear responsibilities for capital investments. Increased role of owners in strategic planning. Public private partnerships;
- Implementation of standards for management and supervisory board activities;

[14] Presentation by Pascal Garel - Chief Executive of HOPE (European hospital and health care federation) during the international conference organized in the framework of the project - November 2006, Sofia.
[15] Presentation by Per Lægreid, Bergen University, Norway during the international conference organized in the framework of the project - November 2006, Sofia.

- Achieving a balance between retaining some vital social functions and increasing income from for-profit services. Effective licensing/accreditation – linking quality of care & financing;
- Elaboration and implementation of human resource strategy;
- Implementation of integrated information systems;
- Training for hospital managers, supervisory boards and owners in health economics and management issues;

Table 16: Specific actions for further hospital reforms in Estonia and Bulgaria

Estonia	Bulgaria
Updating the Hospitals Master Plan taking into account recent developments	Participation in the negotiation process as a separate stakeholder, e.g. increase the role of hospital associations
Development of long term and nursing care to enable further optimization of acute care hospital network	Evaluation of the role of different types of hospitals and strategic plan for further development (small hospitals or those in remote areas)
Development of quality assurance systems and to consider introduction of providers' accreditation system to award good performance	De-monopolization of NHIF and diversification
Enhancement of non-medical services (e.g. client services) in hospitals to increase patients satisfaction	Increase health expenditures as share of GDP
Development of performance monitoring systems for hospitals	Establishment of supervisory boards and strengthening their role
Increase of case based (DRG) payment share as a hospital's remuneration system and consider introduction of performance related payments and contracts (e.g. quality bonus)	Financing outpatient care provided in the hospitals
Ensure sustainable and optimal long term financing for hospital sector, i.e. investments to the infrastructure	Political decision on medical equipment purchasing and funding of capital investments (tax relieves and incentives, etc.)
Increase the competences of hospital's management and supervisory boards by training and sharing best practices	Clear definition of benefit package, covered by the national health insurance fund and regulations for co-payment of services, medicines and consumables
	Establishment of an independent agency for the accreditation procedures
	Reestablishment of the linkages between hospitals and emergency care and between hospitals and outpatient care
	Elaboration of human resource strategy
	Continuity of care, incl. funding long-term care

Conclusions

The opinions about what are the strengths and weaknesses of the hospital reforms in Bulgaria and Estonia vary among different respondents, and within countries. In Bulgaria, the lack of a long-term development strategy for hospital restructuring is causing uncertainty for the future and hampers the willingness of frontline managers and practitioners to actively implement change. In Estonia, the implementation of the hospital Master Plan is considered to be a positive step although for the majority of respondents (especially these in the general hospitals whose status has been changing the most) the reform objectives remain unclear. In both countries it is suggested that the government and the health ministries (Ministry of health in Bulgaria and Ministry of Social Affairs in Estonia) will develop strategy, define clear and specific objectives, ensure that implementation is carefully monitored.

Both countries have transformed their hospital financing models, moving from a planned budget to financing linked to performed activity, and this is viewed positively. However the insufficient financing of the hospital sector is seen as obstructing the achievement of the main objectives of the health care system: quality, access and financial sustainability. While the transformation of hospitals into separate juridical entities (trade companies) increases freedom and operational independence, there are concerns about the social functions of the health care system previously fulfilled by hospitals in the absence of alternative provision of longer-term care. Thus, there is feeling of conflict between public interests and hospitals acting under the civil law (as a market entity).

Regarding hospital autonomy, managers in Estonia and Bulgaria judge their autonomy to be sufficient to manage their facility, although the Bulgarian managers are slightly more cautious in stating this. However, it is clear that the managerial cadres accept the new rights (to allocate resources, spend profit etc.) and responsibilities (manage debt etc.). Yet, the departmental autonomy within hospitals remains limited in both countries, which is likely to constrain efficiency. According to hospital directors and other stakeholders, the competition in the hospital sector is already a fact and ideally this should lead to efficiency improvements. However, most respondents suggest that there is a scope for improving efficiency in the hospital sector generally, but not in their own hospital indicating that not all steps that need to be done are taken on board. Frequently the efficiency and competitiveness of hospitals is undermined by legislation, bureaucracy and red tape. Patient's free choice of physician and hospital is only a theoretical possibility as in reality most people cannot exercise choice due to restrictions due to the existence of multiple barriers related to their ability to pay at the hospitals and mobility. The high level of out-of-pocket and informal payments for hospital care is hardly recognized by staff as a barrier to care, raising some worrying conclusions about the possibility to address this payments in the short term.

The sign of politicising of hospital governance is perceived to be an increasing problem. In this context the roles of management and supervisory boards are not entirely understood and the supervisory boards do not achieve their full potential (in Estonia). In

both countries the inconsistent reform process and the two-speed reform in hospital and primary care has led to antagonism between these two areas; between small (municipal) and large (university) hospitals; between hospital care providers and managers implementing reform initiatives, and policy-makers developing these.

Hospital reform appears to be a very sensitive public issue and therefore more proactive debate and public consultations are needed to ensure involvement of all stakeholders, in order to pursue long term agreement on the further steps and prompt their implementation. Hospital managers believe they have a level of influence but this is not often put to practice beyond local or regional level. All stakeholders need to be more active in seeking innovative and context-specific solutions for restructuring in line with the European and international trends of hospital development. Development and implementation of long-term strategies (as the Estonian Master Plan), development of a human resource strategy and establishment of integrated hospital services linking to other levels of the system, and to other sectors are of immediate priority for the health policy makers.

Exchange of best practices is of vital importance for the health policy makers in order to learn from the experience of other EU and industrialized countries which have decades of experience in hospital reform (e.g. European Union aim to introduce health in all policies[16] and investing in health). The governments' policies in Bulgaria and Estonia have to be based on comprehensive evaluation and analysis of the current and future health and health care needs of the population. Our research has contributed to analyzing the views and attitudes of the relevant stakeholders to hospital reforms across two very different contexts. Further research is necessary to reflect the attitudes of the general population and the opinion of the practitioners working at other levels of health system, and from other sectors, regarding hospital reform and health reform in general.

Rigorous economic analysis is needed in both countries with regard to market features of hospital services – e.g. market concentration, patient flows and ability to substitute among hospital providers, barriers to entry (costs, regulations, etc.) and their implications on the behaviour of hospitals, number, types and behaviours of buyers and respective consequences for hospital services. Comprehensive analysis in both courtiers has to be performed to analyze the hospital ownership and hospital behaviour, role of prices regulations on the hospital behaviour, and the effects of introducing integrated delivery system on the single hospital. Systems for routine monitoring of hospital performance in view of needs and costs of care have to be developed to ensure adequate benchmarking and accreditation across hospitals. Health policy makers may consider strengthening health economics capacity within the respective health ministries or specialised agencies for epidemiology and economic analysis in health care.

[16] This idea has been revived by the Finish government during Finish presidency of the EU through the publication of a book: Health in all policies.

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