



Governance of the health system,  
health insurance fund and hospitals  
in Estonia – opportunities to improve  
performance

**By: Maris Jesse**

**2008**

## Keywords

NATIONAL HEALTH PROGRAMS – organization and administration – standards  
INSURANCE, HEALTH – organization and administration – standards  
HOSPITAL ADMINISTRATION – standards  
ESTONIA

Address requests about publications of the WHO Regional Office for Europe to:

Publications  
WHO Regional Office for Europe  
Scherfigsvej 8  
DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office web site (<http://www.euro.who.int/pubrequest>).

© World Health Organization 2008

All rights reserved. The Regional Office for Europe of the World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.

# CONTENTS

*Page*

Introduction and methods.....	2
System-level governance .....	3
Values and setting objectives on national level.....	7
Conclusions and recommendations.....	10
Governance of the health insurance system .....	12
Introduction .....	12
Legal status.....	13
Ownership.....	14
Mechanisms of representation .....	14
Setting objectives and supervision .....	15
Development plan.....	18
Forms and scope of government supervision .....	19
Reporting requirements.....	21
Auditing requirements .....	21
Linking EHIF governance to health system objectives and effects on health system performance and attaining health system goals .....	22
Conclusions and recommendations.....	23
Hospital governance .....	24
Overview of hospital sector development during the 1990s.....	24
Hospital ownership.....	25
Legal status.....	25
Governance structure and mechanism of representation .....	27
Accountability and setting objectives.....	29
Supervision.....	31
Reporting requirements.....	36
Auditing requirements .....	36
Effects of the hospital governance mechanisms on health system performance and attaining health system goals .....	36
Conclusions and recommendations.....	37
References.....	39



## **About the author**

Maris Jesse is currently the director of National Institute for Health Development in Estonia. She has headed the Estonian Health Insurance Fund, worked as senior health specialist in the World Bank, researcher at PRAXIS Center for Policy Studies and as a senior specialist at Ministry of Social Affairs in Estonia. Maris Jesse is a graduate of Tartu University Medical Faculty and holds a Masters Degree in health policy and finance from London School of Hygiene and Tropical Medicine and London School of Economics and Political Sciences.

## **Acknowledgements**

The author thanks Ivi Normet, Üllar Kaljumäe and Hannes Danilov for being available for interviews during summer and for sharing recent materials. The author is also grateful to Jarno Habicht and Triin Habicht for their comments on draft versions of the study.

The study was supported through a bilateral agreement between WHO and the Ministry of Social Affairs for 2006–2007, which enabled a study on the situation of governance arrangements in Estonia to facilitate policy discussion and further development.

## Introduction and methods

This case study was written for the policy dialogue on health system governance of the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies with Estonia, Latvia and Lithuania held in Pärnu, Estonia on 29–30 August 2007. This policy dialogue hosted by Estonia's Ministry of Social Affairs is the fourth in the series of policy dialogues following those on health financing and purchasing (Tallinn 2004); human resources (Vilnius 2005); and provider networks and integrated care (Riga 2006).

The report aims to give an overview of Estonia's health system governance and its current challenges in three sections.

The first section gives an overview of Estonia's health system, focusing on institutions involved in regulating, providing or funding health services. This case study does not describe pharmaceuticals and public health, although they are part of the health system.

The second section describes in more detail governance arrangements in Estonia's health insurance system and highlights mechanisms for setting objectives and monitoring their attainment.

The third section describes governance arrangements in Estonia's hospital sector, focusing on the role and performance of supervisory boards of public autonomous hospitals.

The case study was written following structured guidelines prepared by the WHO Regional Office for Europe. The study uses Estonia's legislation and materials from web sites of the Ministry of Social Affairs and the Estonian Health Insurance Fund and reviews recent surveys and study reports on governance in Estonia's health sector. These have been complemented by interviews with key policy-makers for more recent updates. The health insurance section also uses the author's own experience from working as the chair of the Management Board of the Estonian Health Insurance Fund. The section on hospital governance also uses the author's interviews in 2004 conducted for the early assessment of the effects of hospital mergers and a round-table discussion on hospital reform in 2006. The study also benefited from discussions and reflections on the initial case study by participants in the policy dialogue.

## System-level governance

Estonia belongs to a group of countries with fairly well-developed governance arrangements. The Worldwide Governance Indicators released by the World Bank (2007) place Estonia in the top 20% of 212 countries assessed, with high scores for regulatory quality, government effectiveness and the rule of law.<sup>1</sup>

The health system governance arrangements in Estonia have developed in accordance with the overall transformation of the economy and state governance in the country. This process has benefited from a surprisingly high level of stability, both in the country as a whole and in the health sector. Following radical reforms from 1991 to 1994, the health system has developed incrementally, staying on the chosen path of social health insurance and autonomous health care providers. This has allowed for gradually building up institutional arrangements, taking into account the overall development of the country's legislative system, the desired roles and capacity of the public and private sectors. The system has been able to respond to problems and challenges as these arise without slipping into crises. Overall, the stakeholders in the system understand quite well each other's roles and what is expected of them.

As depicted in Fig. 1, the main constituents of Estonia's health system related to health care are the Ministry of Social Affairs, Health Care Board, State Agency of Medicines, Estonian Health Insurance Fund (EHIF) and health service providers. The providers have formed both professional associations (such as specialist societies) as well as institutional associations (Hospital Union).<sup>2</sup> The role of other organizations, such as patients' organizations or private insurance, is marginal compared with those mentioned. Estonia's health system has only a few direct subordination relationships, and governance mostly relies on regulation and contractual relations.

Although the Ministry is the main policy-making body and regulator, the Health Care Board is the main agency registering health care professionals, issuing licences to health care providers and supervising health care providers' compliance with input and some process requirements (standards related to facilities, medical technology and medical documentation). County-level administration has a limited role in organizing and supervising primary care. The EHIF administers the public health insurance system, participating also in developing policy and in supervising providers related to health insurance benefits provided to insured people and contractual obligations with the EHIF. Although there are no apparent conflicts of competence or responsibilities between the institutions, there are some occasional overlaps in activities, especially in the supervision activities of the Health Care Board and EHIF and the activities of the EHIF, Health Care Board and the county level in supervising primary care providers (National Audit Office of Estonia, 2007).

---

<sup>1</sup> Voice and accountability – worldwide percentile rank for Estonia 78.8 (regional average for 17 countries in eastern Europe 65.3).

Political stability – 71.2 (regional average 56.6).

Government effectiveness – 85.3 (regional average 62.1).

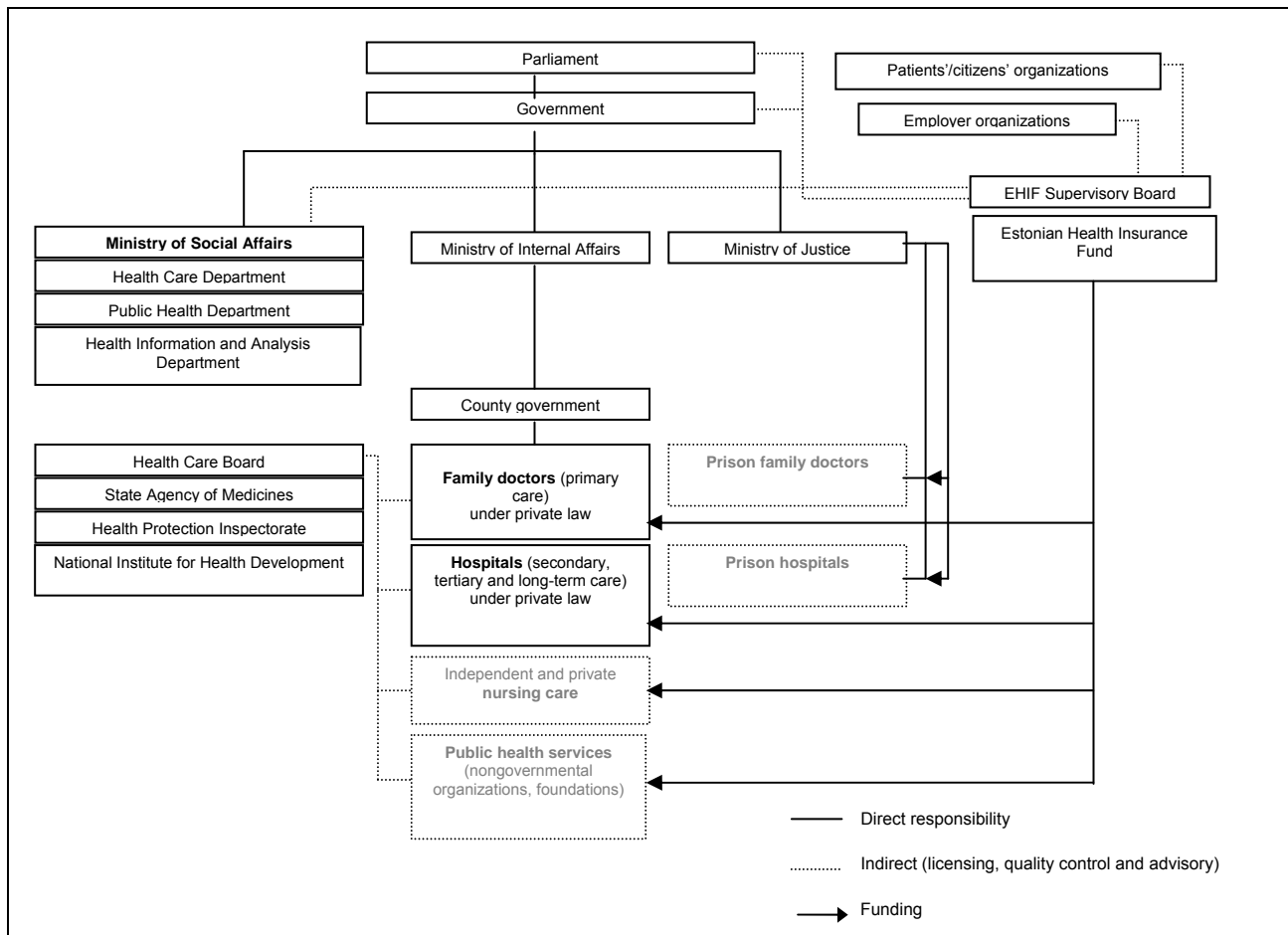
Regulatory quality – 92.2 (regional average 65.7).

Rule of law – 80.5 (regional average 53.3).

Control of corruption – 80.1 (regional average 56.3).

<sup>2</sup> Governance of the pharmaceutical sector is part of the health system but is not analysed here.

Fig. 1. Organization of Estonia's health system, 2007



Policy and legislation in Estonia's health sector are generally developed in a participatory process in which working groups led by the Ministry and comprising representatives of relevant organizations do much of the work. The general aim of the working groups is to reach consensus in their proposals. If consensus cannot be reached, the political leadership will choose between the alternatives discussed in the working groups. In processing draft legislation, the Ministry has to follow a consultation process with stakeholders by sending draft legislation for comment to other government institutions and to nongovernmental stakeholders. The explanatory notes to draft legislation are required to document the consultation process and all proposals received with comments on acceptance and non-acceptance. All draft acts are published on the web site of the Ministry of Social Affairs and on the web site of the Riigikogu (parliament) after they are submitted.

Citizens' direct participation in decision-making is most significant through representation in the Supervisory Board of the EHIF (see the following section on the EHIF) and in the expert committee on the quality of health care under the Health Care Board (the committee is under the Ministry of Social Affairs from 2008 and not the Health Care Board) that has a representative of patients' organizations. Patients' organizations and other nongovernmental organizations also belong to the above-mentioned working groups at the Ministry of Social Affairs when this is considered relevant.

The strongest influence of private industry on health system governance is through employer representatives on the Supervisory Board of EHIF. The private medical industry, including the

pharmaceutical industry, is involved through the working groups and consultation processes of the Ministry of Social Affairs.

No preset conflict mediation processes are usually in place for conflicts between system stakeholders. All organizations have their internal complaint systems as part of quality assurance procedures. The expert committee on the quality of health care handles complaints of suspected medical malpractice, but otherwise there are no other established inter- or supra-organizational bodies. When the differing parties cannot resolve a conflict (insured people and the EHIF, service users and health service providers, health service providers and the EHIF or the Health Care Board and health care providers), a court settles it.

The main quality mechanisms in Estonia's health system include (Pölluste et al., 2006):

- licensing of health care providers and supervision of licensing criteria by the Health Care Board;
- registration of health care professionals by the Health Care Board;
- assessment of professional competence by medical specialist societies;
- requirement for health care providers to have an internal quality assurance system, compiled in a quality handbook;
- medical audits, performed by specialists and funded by the EHIF; and
- the development and dissemination of clinical guidelines, developed by specialists and funded by the EHIF and other organizations.

Various specialist societies have led peer-review projects. In 2007, Estonia's hospitals joined the PATH project for comparing provider performance. It is not yet foreseen, however, that the results would be made public (Koppel, 2007). In 2006, a quality indicator-based financial bonus system was introduced in primary care, which also allows for comparison of primary care doctors based on these indicators.

Benchmarking with private industry is not used, mostly because appropriate comparable indicators from the private sector are not available.

The main powers and authority in Estonia's health system are divided as shown in Table 1.

Table 1. Main powers and authority in Estonia's health system

<b>Health system constituent</b>	<b>Role and responsibilities</b>	<b>Powers and authority</b>	<b>To whom it is accountable</b>	<b>Official and the actual consequences for non-performance</b>
Government, including the Minister of Social Affairs	Policy-maker and regulator	Legislative initiatives to the Riigikogu Adoption of decrees Adoption of national programmes	Ministers to the Riigikogu	Mostly loss of the post and loss of seats in the Riigikogu in the next elections If criminal activity is suspected, court action is taken
Ministry of Social Affairs	Main policy-maker and regulator in health sector	Legislative initiatives to Government and the Riigikogu Adoption of ministerial decrees	Civil servants accountable to the general secretary of the Ministry	Loss of performance-related part of salary or loss of job If criminal activity is suspected, court action is taken
Health Care Board	Registration of health professionals Licensing of providers Supervision of compliance with licensing criteria (inputs and some process requirements)	Issuance and withdrawal of licenses and registration Issuance of orders to correct deficiencies found during supervision	To the Minister of Social Affairs	Loss of job If criminal activity is suspected, court action is taken
County doctors	Planning of primary care network and selection of primary care provider in case of a vacancy	Announcement of the vacancy and selection of the provider	To county governors	Loss of job
Estonian Health Insurance Fund	Administration of the health insurance system	Adoption of contracting principles Selection and contracting of providers Paying providers Paying pharmaceutical benefits to pharmacies and service users Paying sickness benefits to insured people	Representatives of the Supervisory Board accountable to nominating agencies Management Board accountable to the Supervisory Board	For the Management Board and employees, loss of performance-related pay and loss of job In case negligent non-performance ends in a financial loss for the EHIF, financial liability to Supervisory Board and Management Board members
Professional associations	Professional development Assessment of professional competence	Advisory role for public-sector institutions	To members	Low representation of interests and low status compared with other specialists

Health system constituent	Role and responsibilities	Powers and authority	To whom it is accountable	Official and the actual consequences for non-performance
Estonian Family Doctors Association	Professional development as well as representation of interests in developing reimbursement, contracting policy and legislative process	Advisory	To members	Change of management
Hospitals	Financially sustainable provision of high-quality health services		To founding organizations (local governments, Ministry of Social Affairs and universities)	For Management Board – loss of job In some cases loss of performance-related pay
Hospital Union	Representation of corporate interests in reimbursement policies Contracting policy and health care legislative process Management training courses	Advisory	To members	Change of management
Consumers	Representation of consumer interests	Advisory	To members of the respective organization	Withdrawal of representative from working groups etc.

## Values and setting objectives on national level

The main values and objectives that have guided health system development so far have been system efficiency and transparency, professional responsibility for quality improvement and choice for service users (although limited).

Despite numerous initiatives since the mid-1990s to adopt a new national health policy document to replace the one approved in 1995 that would comprehensively describe the guiding values and set objectives for system development, such documents have remained in draft form until 2008. This has mostly been due to the unwillingness of changing political leadership to continue with the process initiated by a political opponent and not so much because of disagreement in terms of content (values and objectives). Although the attempts failed to end in an approved document, the value of the process of developing the drafts cannot be underestimated. During discussions over the years, common understanding and even vocabulary among the changing representatives of the involved stakeholders have been created, and the process has contributed towards finding a consensus on the basic values. In spring 2008, the Ministry of Social Affairs is expected to present a National Health Strategy for discussion in the Government of Estonia, which would complete a preparatory process over the past three years that included extensive discussions and public consultations. The draft of the strategy (Ministry of Social Affairs, 2007) outlines five main themes expected to contribute to the overall objective: increasing life expectancy and healthy life expectancy. It also lists priorities, strategic objectives and measures to achieve the

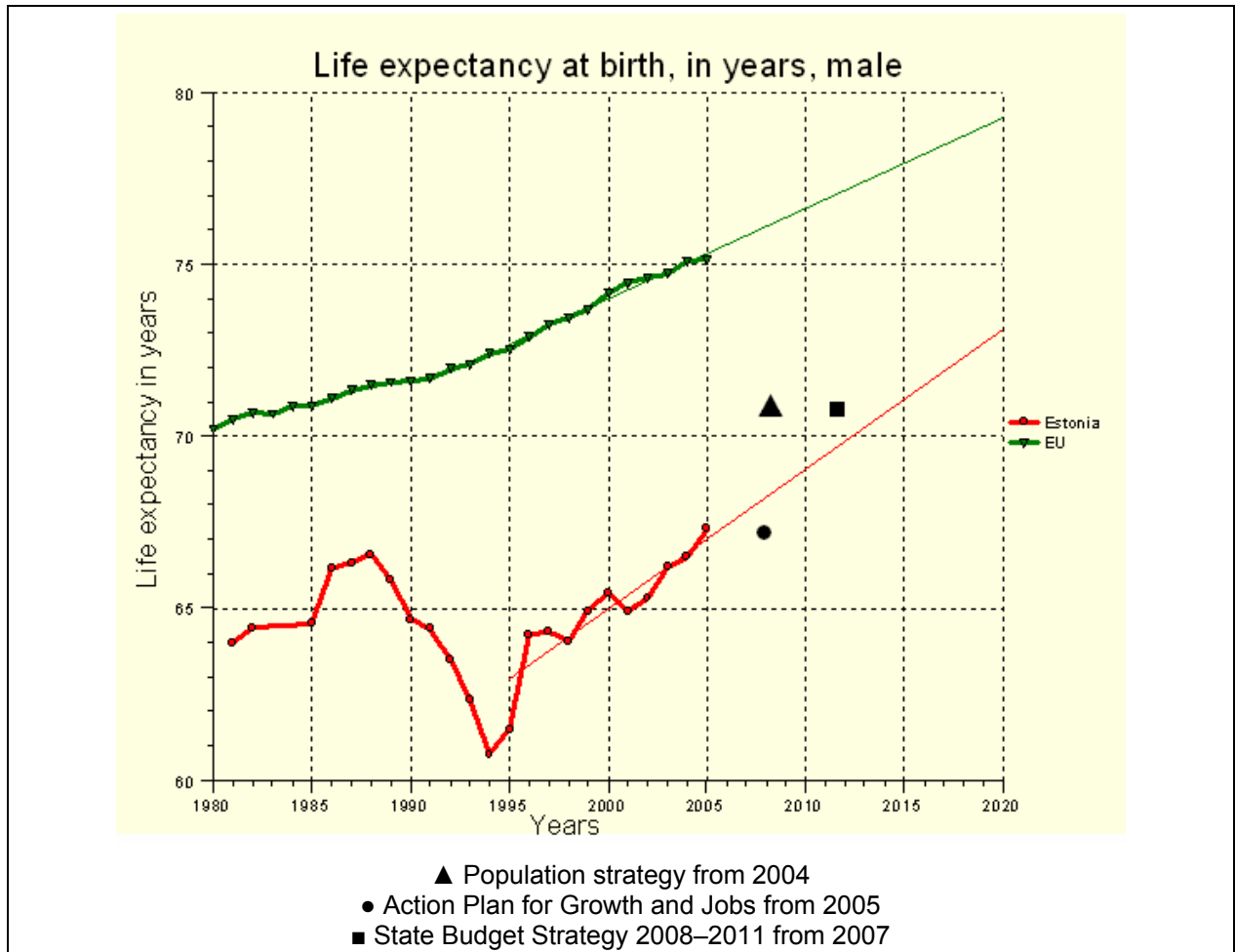
objectives to be taken by the state and gives recommendations for action by municipalities, the private sector and households (Ministry of Social Affairs, 2007).

The efforts to define a clear health policy document during 1999–2007 have influenced other high-level strategic government documents that set several objectives and targets related to the health sector. These are the Government coalition programme, which states that the main objective of the Government is to achieve positive natural growth of the population by increasing the birth rate, increasing life expectancy and improving the quality of life (Government of Estonia, 2007a, Office of the Minister for Population and Ethnic Affairs, 2004). The Estonian Action Plan for Growth and Jobs for the implementation of the Lisbon Strategy, Estonian National Plan for the Use of Structural Funds and three-year state budget strategies set explicit health-related targets such as healthy life expectancy, financial protection and insurance coverage, the long-term sustainability of the health system and the responsiveness of the health system. Specific health sector programmes such as the strategy for HIV/AIDS and the programme for cardiovascular diseases also set specific targets (Government of Estonia, 2007b).

For health insurance, the law has described the main values – solidarity, limited cost-sharing and equal availability of treatment for insured people that does not depend on place of residence. These values are the basis for setting EHIF objectives in the rolling three-year development plans (four-year plans from 2008).

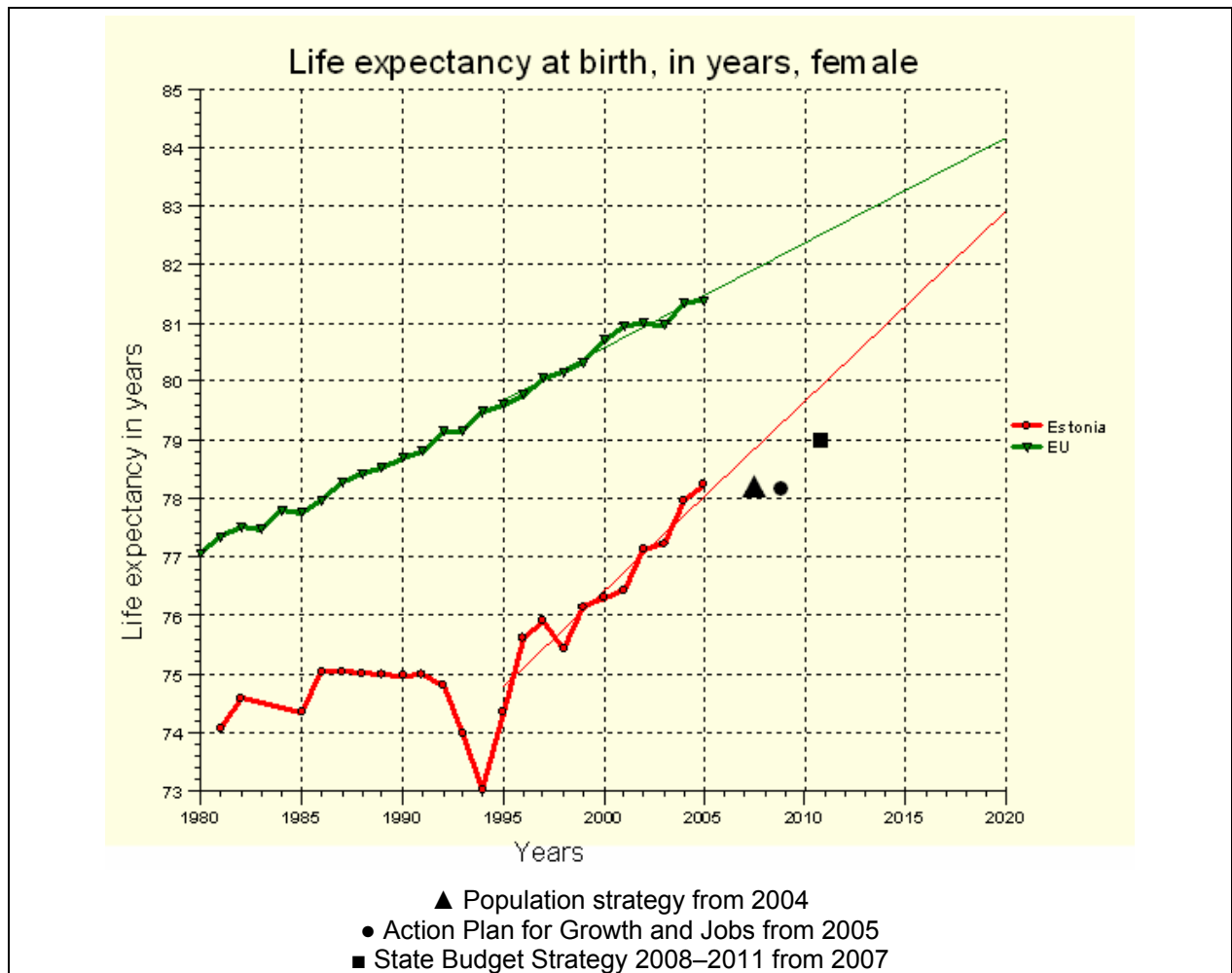
The objectives and targets in these documents are inconsistent but at least not contradictory. The life expectancy targets set in different documents do not seem to be coherent with one another (Fig. 2 and 3). The objectives are sometimes very detailed, especially for the Government programme. Overall, however, the health sector has objectives and targets to be used as a management instrument and to which health sector leaders could be held accountable.

Fig. 2. Targets for the life expectancy of males at birth in Estonia in strategic documents



Source: Government of Estonia, 2007b; WHO-HFA database 2007

Fig. 3. Targets for life expectancy of females at birth in Estonia in strategic documents



Source: Government of Estonia, 2007b; WHO-HFA database 2007

## Conclusions and recommendations

In the decade after the radical reforms in 1992, Estonia built a functioning health system that relies for service provision on autonomous public hospitals, private primary care providers, mainly private outpatient specialists and pharmacies. At the same time, Estonia has succeeded in maintaining mostly public funding of health services, with earmarked health insurance funding supplemented by the state budget. An autonomous public body administers health insurance. The roles of the stakeholders are fairly clearly defined and backed by authority to execute their functions.

The governance of such a system with so many legally autonomous public and private actors relies on regulation and contractual relations. The overall functional status of the system demonstrates that, despite some tensions between stakeholders, the overall regulations are enforced and contractual obligations are respected.

There are, however, some areas for improvement. Health issues have moved up on the political agenda in recent years, and increasing life expectancy and improving the quality of life are seen as measures for achieving natural positive population growth. Several government documents set

targets for life expectancy and healthy life expectancy, and more specific programmes and strategies set more detailed objectives and targets.

There is, however, no practice so far of regular and uniform monitoring and reporting on the achievement of the objectives set in different documents. The absence of an overview of the objectives in different documents has led to a situation that even key stakeholders are not aware of some national-level objectives. This does not allow system stakeholders (such as individual hospitals) to align their objectives to national objectives and to monitor their performance towards national goals.

A process is under way to adopt a National Health Strategy in 2008 as an overarching strategic document to guide key activities that are expected to affect health improvement in health as well as other sectors of the economy.

To increase the leadership role of the Ministry of Social Affairs in coordinating health issues across sectors, as well as health sector focus on health outcomes, the Ministry of Social Affairs may consider the following recommendations:

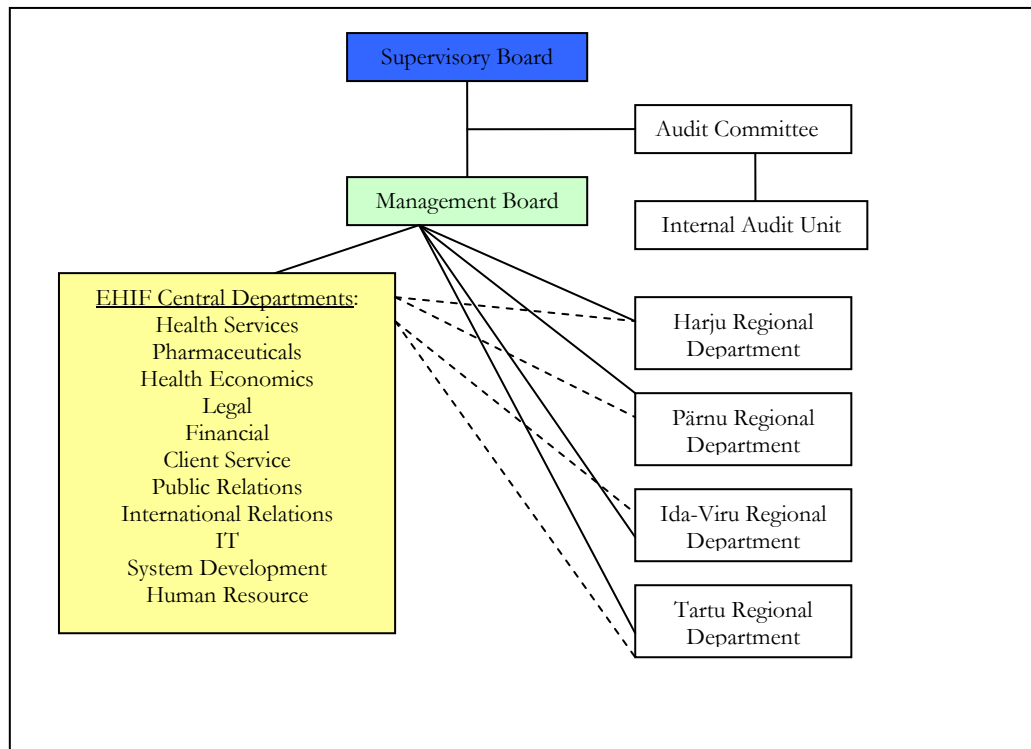
- finalizing and approving a national health policy or strategy document;
- starting and maintaining an overview of health-related objectives in government documents and in the programmes of other sectors;
- establishing a regular monitoring and public reporting mechanism on the achievement of these objectives;
- establishing a regular forum for information and discussions on health issues, such as an annual or biannual health policy conference; and
- further improving the active engagement of partners and representatives of interest groups (such as professions and service users) in policy debates and developing regulation, building on the existing mechanisms.

## Governance of the health insurance system

### Introduction

Estonia's single public health insurance system is administered by a public independent legal body – the EHIF, which had the following organizational structure in 2007.

Fig. 4. Organizational structure of the EHIF in 2007



The governing body of the EHIF is the Supervisory Board, which has 15 members – 5 members representing the state, 5 employers' organizations and 5 organizations of insured people.

The EHIF Management Board, consisting of three to seven members (three in 2007), is responsible for operational management. The Supervisory Board appoints the chair of the Management Board in an open competitive recruitment process. The Supervisory Board appoints other Management Board members based on the recommendation of the Chair of the Management Board.

The EHIF is managed based on a matrix principle, the central departments leading strategic development, overall planning and control of financial resources and guiding and supervising regional departments in the respective areas. The responsibilities of regional departments, each covering 200 000 to 500 000 insured people, have decreased over time. Currently the regional departments are responsible for regional assessment of population health needs, preparation of a contracting plan with providers in the region in accordance with national planning and contracting providers in accordance with the authority delegated by the Management Board. The regional departments are also responsible for claims processing and client services. Until 2006, the regional departments also had small offices in each county with the main task of providing client services, including relations with employers and the population in all questions related to

health insurance. The offices were closed because they were administratively inefficient. The network of offices of the national postal company Estonian Post are now providing some of the functions of these client services offices paid by fees from the EHIF.

## Legal status

Since 2001, the EHIF has been a public independent legal body, established by the Estonian Health Insurance Fund Act (Riigikogu, 2000). This Act describes the objective, functions, bodies, assets and obligations of the EHIF. The statutes of the EHIF, which are approved by the Government, regulate more specific details of organization, such as the rules of procedures of board meetings and the budgetary process.

Although the autonomy of the health insurance system has varied somewhat since health insurance was launched in 1992, the system has always had more autonomy than the core government agencies and civil service. Further, in contrast to other government entities, there has been civil oversight over the system through the Supervisory Board, which has had both a decision-making and advisory role in different periods. In the first two years 1992–1993, 22 regional sickness funds operated as separate public independent bodies. Over time, the framework laws for public administration changed, and the legal status of the Central Sickness Fund and the regional sickness funds became unclear and allowed different interpretations regarding subordination relations and accountability mechanisms between the Ministry of Social Affairs, State Social Insurance Board, Central Sickness Fund and regional sickness funds. By the end of the 1990s, the legal ambiguity of the Fund's status had started to adversely impact the Fund's performance, especially in relation to developing contracting with health care providers, most of which had started to operate in various private forms.<sup>3</sup> The process of approving the health insurance budget as part of the state budget approval by the Riigikogu had proven to be too rigid for detailed needs-based planning and was therefore too general and lacked transparency. The health insurance system also required organizational reforms, which could not be undertaken without clarity on whether civil service or labour law regulations should be followed (Jesse et al., 2004).

Following an analysis of options for legal status carried out by independent and renowned legal consultants, three different alternatives – a state agency, foundation and independent public legal entity – were considered, and the Government chose the last option – the EHIF as an independent public legal entity.

Public legal entities are established in Estonia case by case through separate acts that stipulate the bodies and responsibilities of the established entity. This was seen as a good opportunity to solve the ambiguous legal situation and to assure a stable legal environment for health insurance administration. Other important considerations were that a public entity has a full right to enter into contractual arrangements. Further, civil service regulation does not apply to the EHIF, and its staff members are not civil servants, allowing for more flexible recruitment and remuneration policies (Jesse et al., 2004).

---

<sup>3</sup> Until 2001, the health care providers operated as general partnerships, limited partnerships, private limited companies, public limited companies, commercial associations, foundations, not-for-profit associations, self-employed people and state or municipal agencies.

## Ownership

The EHIF owns its assets and can use its assets according to the procedures stated in the Estonian Health Insurance Fund Act and the statutes of the EHIF. As a safeguard, the statutes stipulate that the state cannot use the EHIF's assets for other purposes. If the EHIF is dissolved, the remaining assets are transferred to the state.

The income of the EHIF mainly comprises the health insurance tax collected in the state budget, which constitutes about 99% of the EHIF revenue base. The remaining revenue is premiums paid by people covered by voluntary contracts and interest earned on reserve investments.

According to the Health Insurance Fund Act, EHIF cannot go bankrupt. EHIF is fully liable for its obligations with all its assets. However, the state becomes responsible for EHIF's obligations in two cases: if health insurance tax revenue is lower than forecast in the state budget or if the Minister of Social Affairs or Government establishes prices or rates of health insurance benefits at a level that prevents the EHIF from fulfilling its contractual obligations or from paying health insurance benefits. If the Government increases reimbursement rates so that expenditure exceeds the revenue of the EHIF and the EHIF's budget is insufficient to cover additional obligations, the state has to assume these obligations. In theory, there is a clear incentive to exceed the EHIF's budget. In practice, however, this has not yet happened. When health care professionals exercised pressure to increase reimbursement rates in 2004 with strike threats, the Management Board and Supervisory Board sought solutions within the existing revenue and felt accountable for long-term financial sustainability (Habicht, in press).

## Mechanisms of representation

The highest body of the EHIF is the tripartite Supervisory Board with 15 members – 5 from the state, 5 from employers and 5 representatives of insured people.

Three of the state representatives are ex officio board members: the Minister of Social Affairs, the Minister of Finance and the Chair of the Riigikogu Committee on Social Affairs. The fourth state representative is a member of the Riigikogu, who is nominated by the Riigikogu Committee on Social Affairs and appointed by the Riigikogu. The fifth state representative in the EHIF Supervisory Board is an official of the Ministry of Social Affairs appointed by the Government based on the recommendation of the Minister of Social Affairs. Although it was intended during the drafting of the Estonian Health Insurance Fund Act that the fifth representative be a high-level civil servant, during 2004–2006 a politically appointed Assistant Minister represented the Ministry.

The Government formally appoints the remaining 10 members: 5 nominated by organizations representing the interests of insured people and the other 5 nominated by organizations representing employers. Although the Government formally appoints these 10 Supervisory Board members, they can be appointed and withdrawn not on the Government's own initiative but solely based on nominations by the organizations.

The Government prepares a list of representing organizations. Among employers, all five members are nominated by the Estonian Employers' Confederation, the most prominent employer's organization in Estonia and representing employer organizations in negotiations with the state and the trade unions. The representatives of insured people are nominated by two

organizations representing employees (the Association of Estonian Trade Unions and the Estonian Professional Employees' Unions Association), the Pensioners' Association, the Chamber of Disabled People and the Union for Child Protection.

The Estonian Health Insurance Fund Act requires that all Supervisory Board members have permanent residence in Estonia, an impeccable reputation and the knowledge necessary for participating in the Supervisory Board.

The term of authority for ex officio Supervisory Board members is related to their position. The term of authority of other Supervisory Board members is three years, and they may not be appointed for more than two consecutive terms. Supervisory Board members who are not in their position ex officio are remunerated at the minimum wage for the hours worked. The Supervisory Board has on average one meeting per month, lasting two to three hours.

The chair of the Supervisory Board is ex officio the Minister of Social Affairs. This mechanism was adopted when the Estonian Health Insurance Fund Act was drafted to respond to concerns raised by the Ministry of Finance and Ministry of Justice, officials of which opposed EHIF becoming a public independent body. The main questions these ministries raised were issues of political accountability and of financial sustainability and transparency. It was questioned how the Minister of Social Affairs can be held accountable for key health insurance decisions against which the Minister has voted in the Supervisory Board. To increase the Minister's role and accountability, it was decided that the Minister would automatically chair the Supervisory Board, and the chair was also given a de facto right to veto the approval of the EHIF's budget and setting maximum limits for waiting times. These decisions require the chair to support the decision.

The members of Supervisory Boards have different backgrounds. To build the capacity of the Supervisory Board, the EHIF has started to organize an annual orientation session on health system issues.

A contentious issue is the role of health care providers in the Supervisory Board of the EHIF. During the 1990s, health care providers had a seat in the health insurance advisory boards working at the central and regional levels of the system. Experience showed, however, that conflicts of interest occurred, and therefore no dedicated seat was foreseen in the EHIF Supervisory Board from 2001 onwards. Nevertheless, health care providers have been appointed to the Supervisory Board as employer representatives as well as through organizations representing employees and the Union for Child Protection. At times, the health care professionals in the Supervisory Board have represented the positions of health care providers, especially when the Supervisory Board discusses contracting policy, provider payment mechanisms or reimbursement rates (Habicht, in press).

## **Setting objectives and supervision**

Box 1 lists the Supervisory Board competencies stipulated by legislation. If the Supervisory Board does not decide otherwise, the Management Board prepares the materials and drafts decisions to be discussed by the Supervisory Board. In addition, at the request of the Management Board or its chair, the Supervisory Board may decide on other issues related to the EHIF. All Supervisory Board decisions are public and are published on the EHIF web site.

The Supervisory Board is responsible for supervising the activities of the Management Board and for examining all necessary documents to audit the accuracy of accounting, the existence of assets and the conformance of the activities of the EHIF with legislation, the EHIF statutes and the decisions of the Supervisory Board. This can be done by Supervisory Board members themselves or can be delegated to other bodies by the SB.

Members of the Supervisory Board are jointly liable for any damage wrongfully caused to the EHIF by violating the requirements of legislation or the EHIF statutes or by failing to perform their duties. The EHIF has a liability insurance policy to insure members of the Supervisory Board against the possible losses with a deductible established in the statutes of the EHIF (about €3200 per member in 2006).

**Box 1. Competencies of the EHIF Supervisory Board**

1. Approving the development plan of the EHIF
2. After hearing the opinion of the Management Board, proposing to the Minister of Social Affairs to make a proposal to the Government of the Republic for establishment or amendment of the list of health services of the EHIF
3. Approving the maximum length of a waiting list
4. Proposing to the Minister of Social Affairs the establishment of a list of medical devices of the EHIF
5. Approving the standard conditions of contracts, the evaluation criteria for selective contracting and the term of the contracts provided
6. Approving the EHIF budget in accordance with the state budget based on the recommendation of the Management Board
7. Approving, based on the recommendation of the Management Board, the structure of the EHIF
8. Approving the statutes of the departments of the EHIF
9. Approving the statutes for the maintenance of the health insurance database based on the recommendation of the Management Board;
10. Approving the accounting procedures based on the recommendation of the Management Board
11. Deciding on the acquisition, transfer and encumbrance of immovables and of movables that are entered or must be entered in the register and on the taking of loans, all based on the recommendation of the Management Board
12. Appointing or removing the chair of the Management Board
13. Appointing or removing members of the Management Board on its own initiative or based on the recommendation of the chair of the Management Board
14. Deciding on entering into a contract of service with the chair of the Management Board and on entering into contracts of service with the members of the Management Board on the recommendation of the chair of the Management Board
15. Deciding on the filing of proprietary claims against members of the Management Board
16. Approving remuneration of and additional sums payable to the chair of the Management Board and members of the Management Board after hearing the opinion of the chair of the Management Board
17. Approving reports submitted by the Management Board and the requirements set for the reports
18. Designating an auditor for the EHIF and deciding on the amount of remuneration of the auditor after hearing the opinion of the Management Board

## Development plan

The objectives of the EHIF have been set in the development plan since 1999 (EHIF, 2006, 2007a). This covers a three-year period (four years from 2008) and is reviewed and updated annually. The principle behind the development plan is to focus on the issues of highest importance, to set clear and measurable objectives to better communicate the achievements to the public and to involve the Supervisory Board in developing strategy. The balanced scorecard method was considered an appropriate tool for translating the strategy into measurable objectives that drive performance at all levels of the organization.

The EHIF development plan includes the mission statement, describes the values guiding EHIF work, sets strategic objectives and measurable targets to assess the achievement of objectives and lists activities to be undertaken to achieve the objectives (Habicht, in press).

Until 2006, the mission statement of the EHIF was "... to allow the insured people to feel secure when possible health problems arise by affording access to high-quality health services and other health insurance benefits" (EHIF, 2006). From 2007, the mission statement was changed to be more low-key: "to assure access to health insurance benefits and the sustainability of the health insurance system" (EHIF, 2007a).

The objectives of efficiency and quality of health services and of organizational effectiveness have remained the most important strategic objectives since 1999, but the activities to achieve these have changed. Some activities have been completed but some have been dropped because policy has changed. Box 2 describes the strategic objectives in the Development Plan for 2007–2009 (EHIF, 2007a), approved by the Supervisory Board on 19 January 2007.

### **Box 2. Strategic objectives of the EHIF, 2007–2009**

1. To assure access to health services, pharmaceuticals and cash benefits
  - To assure universal access
  - To develop partner relations and guarantee the fulfilment of contractual relations
2. To develop the quality of health care system and health services
  - To enhance the development of the quality of health care services
  - To enhance quality assessment and control in health services
3. To assure the financial sustainability of the health insurance system through purposeful planning and the use of health insurance resources and efficiency
  - To enhance needs assessment and the planning of health insurance benefits, balancing needs with budget availability
  - To enhance the efficiency of health insurance expenditure
4. To assure the awareness of clients and partners of their rights and obligations
5. To increase administrative efficiency
  - To develop staff competence and motivation
  - To use a standardized information system with broad functionality

The Supervisory Board reviews the strategy annually and approves the reviewed strategy with set goals and planned priority initiatives for the current year and the scenario for following two or three years.

The rolling out of the strategy into individual-level action plans is an elaborate process that has been in place since 2001. After the Supervisory Board approves the strategy, the Management Board discusses with unit directors and agrees on the unit objectives. This is followed by drawing up one-year department scorecards and translating these into the two half-year scorecards for the units where specific measures and initiatives are set up. Finally, unit scorecards are cascaded into individual scorecards for each staff member. These activity scorecards are linked to the organization resource management information system, which is based on an activity-based costing model. This enables the activities to be related to the resources needed and makes the internal administrative system transparent and in accordance with strategic objectives. The achievement of objectives in the scorecards forms the basis for the staff performance-related part of the salaries, which is assessed twice a year. The Management Board's performance-related part of salary is linked to the achievement of overall objectives and is assessed when the annual report is approved. The performance-related pay is a maximum of 30% of the annual fixed salary (EHIF, 2007b). This transparent and corporate strategy-oriented approach has prompted the staff to think more strategically and has facilitated all levels in speaking in a common language (Habicht, in press).

## **Forms and scope of government supervision**

The aim of the legal status changes in 2001 was to give the EHIF quite broad autonomy to contract with service providers but also to maintain a strong regulatory and supervisory role for the Government. The Riigikogu and the Government make important health policy decisions about the health insurance system such as the insurance premium (rate of tax), coverage entitlements and scope of benefits (Box 3).

### **Box 3. Regulation of the health system**

**Establishment of the system (objectives and principles)** – Health Insurance Act (effective since 2002)

**Contributions definition** – Social Tax Act (effective since 2001)

**Contributions rate** – Social Tax Act

**Coverage (eligibility)** – Health Insurance Act

**Co-payments** – general regulation as upper limits and principles in the Health Insurance Act; actual co-payments of health services in the Government regulation List of Health Services and of pharmaceuticals in the Ministry of Social Affairs regulation Reference Prices of Pharmaceuticals and List of Reimbursed Pharmaceuticals

**Benefit package** – basic principles in the Health Insurance Act; the Government regulation List of Health Services defines the actual benefit package

**Provider payment methods** – Government regulation List of Health Services and the application rules in Ministry of Social Affairs regulation

**Prices (level of funding)** – actual prices in Government regulation List of Health Services; price calculation method in Ministry of Social Affairs regulation

**Contracting** – basic principles (list of criteria for provider selection, terms and necessary parts of contracts) in the Health Insurance Act; the Supervisory Board decides the rules for applying provider selection criteria

**Budget** – basic principles in the Health Insurance Act; the Supervisory Board decides the line items in detail

**Waiting time limits** – Supervisory Board decision

In reality, however, the EHIF drafts most legislation governing the health insurance system (or EHIF representatives are strongly involved as health insurance experts) and forwards the drafts for further processing to the Ministry of Social Affairs after the Supervisory Board approves them. This also applies to most of the regulations related to health service reimbursement rates.

As one of the main objections to giving the EHIF independent status was concern about its financial sustainability, the solvency of the health insurance system is extensively regulated (Jesse et al., 2004).

Firstly, in accordance with common fiscal policy in Estonia, the budget of the EHIF must set out the balance of the revenue and expenditure of the EHIF for one fiscal year.

The EHIF has three types of reserves to ensure solvency. The first one is the cash reserve (liquidity portfolio), which has to ensure daily smooth management of cash flows. The liquidity portfolio, which the State Treasury administers by contract, comprises such instruments as local deposits and commercial papers.

The second type of reserve is the compulsory reserve to reduce the risk that macroeconomic changes may harm the health insurance system. This reserve has to be at least 6% of the EHIF's annual budget and is built up over several years. Before 2004, the reserve requirement was 8% of the EHIF's budget, but this was reduced to cover the additional expenditures of increased tariffs due to the new salary agreement with health professionals. This reserve may only be used by an

order of the Government on the recommendation of the Minister of Social Affairs. Previously, the Minister of Social Affairs had to hear the opinion of the EHIF's Supervisory Board. The Minister of Finance administers the reserve, ensuring the preservation, liquidity and productivity of the reserve funds. Both the Government and the Minister of Finance can establish restrictions on the deployment of the reserve to reduce currency, credit and liquidity risks. The reserve is mainly invested in the bonds of highly rated European issuers, and a small share is also commercial papers of Estonian banks (Habicht, in press).

The third type of EHIF reserve is the risk reserve, with the objective of minimizing the risks arising for the health insurance system from the obligations assumed. The risk reserve has to be at least 2% of the EHIF's annual budget and can be used based on a decision of the EHIF Supervisory Board.

## Reporting requirements

The formal reporting requirements of the Estonian Health Insurance Fund Act stipulate that the Supervisory Board should present the EHIF annual report to the Government through the Ministry of Social Affairs. The annual report is required to be published in the State Bulletin as well as on the EHIF web site. The Management Board is required to present an overview of the activities and financial situation of the EHIF to the Supervisory Board at least once every three months. The Act stipulates that the quarterly reports are required to be published only on the EHIF web site.

A Supervisory Board decision establishes the reporting standards. Accordingly, the activity report has to adequately inform about the health insurance benefits received by insured people. The financial report has to allow comparison with previous periods and accurately reflect the EHIF's financial situation.

The activity report describes the achievement of objectives as established in the development plan and provides information on the utilization of health insurance benefits by type of benefit. The reporting follows a bottom-up approach. First, each staff member reports about the achievements in the previous period in his or her scorecard. Then unit directors evaluate the fulfilment of unit scorecards and report to the Management Board, which in turn reports the organization's results to the Supervisory Board (Habicht, in press).

The quarterly and annual activity and financial reports are public and have been published on EHIF's web site since 1997, when the web site was created.

Since 2003, the EHIF's annual report has received the annual Public Sector Transparency Flagship award from an independent Accounting Chamber as the most transparent annual report with the best content in Estonia's public sector.

## Auditing requirements

The EHIF is required to be audited by an external independent auditor selected by the Audit Committee of the EHIF. The Audit Committee is a Supervisory Board committee with the main task of organizing the EHIF's external and internal auditing. The external auditor audits the EHIF annual report with the main emphasis on financial issues and less on performance.

The Internal Audit Department, which is accountable to the Audit Committee, carries out internal auditing. The Internal Audit Department audits compliance with internal procedures and with health insurance legislation and makes suggestions for operational procedures.

The EHIF is also audited by the National Audit Office, which can audit the annual report as well as performance issues. The aim of performance audits is to control whether public resources are used purposefully and all the delegated functions are carried out. These performance audits are thematic and usually cover several institutions. Some performance audits have covered EHIF's area of responsibility. The main outcome of these audits is recommendations in published audit reports. However, this kind of audit has little impact (Habicht, in press).

## **Linking EHIF governance to health system objectives and effects on health system performance and attaining health system goals**

The current governance structure of EHIF was established during the development of the Estonian Health Insurance Fund Act to promote social partnership, transparency, sustainability and efficiency and to ensure that EHIF management is depoliticized. To achieve this, lessons learned during the 1990s both in the administration of health insurance as well as more widely in the public sector were taken into account, especially from the other public independent bodies such as Eesti Rahvusringhääling (Estonian Television and Radio) and the universities. The working group developing the governance mechanisms included highly prominent private lawyers, thus also drawing on the best practices of the private sector.

The governance mechanisms chosen in 2001 have been appropriate to the objectives established. The employer organizations and representatives of organizations of insured people have an important voice in the Supervisory Board, contributing to the transparency and sustainability of the EHIF. On more than one occasion, social partners have not supported short-sighted proposals from some politicians that would have jeopardized the sustainability of the Fund. Employer organizations and trade unions participate in public debates on health insurance issues.

Legislation already requires that EHIF objectives be linked to national health policy. The statutes of the Estonian Health Insurance Fund stipulate that the EHIF has to be guided by national health policy. In the absence of the policy as a written document, the objectives of health service access, high quality and health system efficiency in the EHIF development plan have been set based on assessment of public interest and concerns. Lately, Government programmes have already set these objectives, especially related to access. The extent to which the objectives are achieved is monitored through EHIF quarterly and annual monitoring and reporting mechanisms.

The EHIF promotes efficiency in Estonia's health system. The EHIF cannot directly influence its revenues by changing the tax rate and improving tax collection and has restricted influence over the scope of the benefit package. Increasing system efficiency is therefore the only measure available to the EHIF to improve access to service users within the revenue limits. The main instruments used are changes in provider payment methods and refining contracting practice.

Of the three internationally defined health system goals (health gain, health system responsiveness and financial protection), the EHIF has set an explicit objective only for responsiveness and monitors this through annual health system satisfaction surveys. Financial protection depends on political decisions on co-payments and national-level resource allocation, which is within the domain of Ministry of Social Affairs. The level of health and equity in health

were assessed as having too many confounding factors to be set as EHIF objectives to which EHIF can be held accountable.

## **Conclusions and recommendations**

Most stakeholders agree that the current set-up of health insurance system governance is quite balanced and has assured the stable development of the system. No major changes are therefore foreseen or proposed. Although the EHIF is highly regulated and the Riigikogu and the Government make the important decisions on the tax rate and scope of the benefit package as well as reimbursement rates, the EHIF seems to represent a balanced compromise for now in Estonia between those who believe the role of the state should increase and those who would like to see a lesser role.

It is recommended that EHIF continue and further improve its successful activities in strategic planning, aligning objectives with national documents and reporting on progress towards these targets.

The EHIF's role as a strategic purchaser requires also continually defining and redefining its role as a strategic partner to the health care professions and hospital boards, in their pursuit of the objectives of service quality, efficiency and responsiveness. The EHIF has also a role in aligning its partners' objectives with national objectives (Veillard et al., 2005).

An issue arising from time to time related to EHIF governance arrangement is the role of health care providers in the Supervisory Board of the EHIF. Although providers are experts in health sector issues and thus enrich the discussion at the Board level, providers also have vested interests. Further, a hospital or a specialty represented in the EHIF Supervisory Board level may be able to influence a decision in its own favour at the expense of another.

To reduce these risks, it is recommended that the EHIF Supervisory Board approve a code of conduct, which stipulates declaring conflicts in decision policy and abstaining from decisions involving a possible conflict of interest.

## Hospital governance

### Overview of hospital sector development during the 1990s

During the 1990s, the number of hospital beds and hospitals in Estonia was halved. The reduction of beds was mostly a response by hospital management to financial incentives embedded in the health insurance reimbursement policy. The Ministry of Social Affairs managed to reduce the numbers of hospitals by licensing and merging hospitals.

From 2000, the most significant policy influence in the hospital sector was the Hospital Master Plan 2015, which the Ministry of Social Affairs commissioned in 2000 to make projections for future need for hospital capacity. The consultants assessed that, despite reductions in the 1990s, Estonia's hospital network still has excess capacity of acute care hospital beds and a low bed occupancy rate. The share of day care was low, the average length of stay in acute inpatient care too high and some specialties had too small service areas to maintain medical competence. Consultants recommended reducing the number of acute inpatient beds by two thirds and concentrating acute inpatient care in 15 larger hospitals, reducing the total number of hospitals, through mergers and other types of restructuring, by three quarters (from 68 to 15) by 2015. The criteria used in the study for planning future hospital capacity included: (a) sufficient population pools to support minimum service volume for quality and efficiency; (b) development of medical technology; (c) demographic and epidemiological projections; and (d) a requirement that a hospital not be further away than 60 min travel time by car (70 km) (Hellers et al., 2000).

Despite negative reactions to the Hospital Master Plan 2015 by local communities and small-town hospitals, the Ministry of Social Affairs followed these principles in developing regulations for hospital geographical access and for hospital categorization. In addition to the Hospital Master Plan 2015, regional development plans by counties (15 in total) and by medical specialties were developed during 2001, which was the first time county doctors and specialist associations explicitly formulated their long-term plans.

Based on these plans and the Hospital Master Plan 2015, the Ministry of Social Affairs prepared a modified Hospital Network Development Plan (Government of Estonia, 2003), which the Government approved in April 2003 after a series of consultations and some compromises. The Hospital Network Development Plan listed three objectives for hospital sector development: (1) to ensure access to high-quality medical care, (2) to optimize the costs for establishing and operating the hospital network and (3) to ensure the sustainability of the hospital network. To assess the achievement of these objectives, measurable targets were set:

- to reduce the average length of stay in acute care from 6.7<sup>4</sup> in 2001 to 4.6 in 2015
- to reduce acute care beds from 6500 in 2001 to 3200 in 2015
- to increase the bed occupancy rate in acute care from 67% in 2001 to 83% in 2015.

The Hospital Network Development Plan stipulates 19 active care hospitals (rather than 15 as recommended in the Hospital Master Plan 2015) that are eligible for long-term contracts with the EHIF and state-supported capital investment. Other hospitals were foreseen to be transformed into long-term care or small local hospitals.

---

<sup>4</sup> The numbers in the original document diverge from the current statistics available, which may be due to the corrections in the definitions of indicators and methods of calculation.

Legislation establishes seven types of hospitals in Estonia: regional hospital, central hospital, general hospital, local hospital, specialized hospital, rehabilitation hospital and nursing hospital; the first four types are acute care hospitals. Each type of hospital has specific regulations established by Ministry of Social Affairs such as the list and scale of services to be provided by each type of hospital and standards for the rooms, medical equipment and health care staff. By 2005, each hospital had to get an activity licence according to the type, which lasts for 5 years.

At the end of 2005, Estonia had 54 hospitals: 3 regional, 4 central, 12 general, 3 rehabilitation, 20 long-term, 6 local and 6 specialized.

## **Hospital ownership**

In Estonia, public hospitals dominate the hospital sector. Most hospitals are owned (or founded) by state, local governments or public legal bodies (such as the University of Tartu). Of the 54 hospitals, only 6 are private hospitals.

In many instances, a hospital has multiple owners, with several municipalities owning one hospital or the state and municipalities jointly owning one hospital.

Although having multiple owners could benefit the hospital in theory by broadening the base of financial support, analysis has shown that having multiple owners may weaken the owners' motivation to take responsibility for the performance of the hospital. This has been expressed in reduced willingness to invest in the hospital by the owners or in difficulty in agreeing on the investment between the different owners. Situation with multiple owners may also lessen the opportunity to hold owners directly and publicly accountable for hospital performance (Habicht et al., 2006).

Most public hospitals own their assets, with a few exceptions in which the municipality has retained ownership of the buildings and land and leased it (including arrangements without fee) to the hospital only for use.

## **Legal status**

Since 2002, all hospitals have been required to act as joint stock companies or foundations. This legislative requirement in the Health Services Organization Act did not constitute a major change from previous policy but was rather a somewhat delayed regulation of the de facto situation. Hospitals have been autonomous in their activities from the early 1990s, having had full managerial rights in personnel policy, purchasing equipment, taking financial obligations on the hospital and in reality also having full residual claimant status. The requirement to define hospitals as joint stock companies or foundations clearly regulated the rights and responsibilities of hospital managers (Jesse et al., 2004).

Nevertheless, the question of whether private legal status is suitable for public hospitals is still raised in Estonia. The main concerns are related to whether private status for hospitals is compatible with public funding of services, the main aims of hospitals operating as private entities and whether the hospitals become too focused on earning profit (Fidler et al., 2007). Habicht et al. (2006) studied the perceptions of risks from the private status of hospitals by using postal questionnaires and face-to-face interviews with hospital managers and supervisory board members.

Concerning private legal status, the hospital managers did not see risks to public interests. As one interviewee mentioned: “The private legal status does not disturb everyday activities. There might be more problems if hospitals were fully privately owned.” Thus, as most hospitals are publicly owned, there is enough scope for public-sector supervision (Habicht et al., 2006).

There has also been concern as to whether a joint stock company is an appropriate form, and the Ministry of Social Affairs discussed a proposal to allow public hospitals to operate only as foundations.

The Commercial Code regulates joint stock companies, and the Foundations Act regulates foundations. Although the two legal options do not differ substantially in running a hospital, some features differ, which have been the focus of the recent debate in Estonia.

One is the issue of the objective of an organization. Generically, a joint stock company is understood to be a business organization, and it is therefore expected that its main objective is to maximize profit, which is not considered appropriate for publicly owned hospitals. Some hospital managers also claimed that “Joint stock company as a legal status is not good for a hospital as then the hospital should be profit oriented and then half the patients might get no treatment.” In reality, no law stipulates that a joint stock company has to maximize profit; legislation says that it should act economically reasonably. This was also summarized by one hospital manager: “For a foundation, all decisions are good that ensure accomplishment of the mission, but for a limited stock company the decisions should also be economically sound!”. It was also mentioned that being a foundation does not ensure that a hospital will not maximize profit: “If the attitude is ‘competition whatever it takes’, then public interests are not followed. There might be even competition between different departments within one hospital.” (Habicht et al., 2006).

One of the worries expressed related to joint stock companies was that other objectives (such as social ones) become less important. At the same time, managers of joint stock companies did not share this worry: “Our immorality in joint stock companies is not such that we would become oriented only to profit maximization. It is not the interest of owners, also.” Some interviewees recognized that joint stock companies can have other objectives than only maximizing profit, if this is the will of its owners: “Legal status is not the most important, as there are many other aspects that influence representing public interests. Legal status does not influence negatively hospitals in acting in the public interest.” (Habicht et al., 2006).

The differences between joint stock companies and foundations were seen mostly in treatment of profits and in financial supervision. On the negative side, it was seen as a threat that the public owner can take out profit from hospitals operating as joint stock companies and not reinvest it in the hospital. So far, this is more a theoretical than actual situation. More strict regulation of financial supervision was seen to be an advantage for the joint stock company option: “Limited stock companies are much more secure organizations, as they are under much stronger supervision. Foundations can work under break-even for a long time; a limited stock company cannot.” This is accompanied by greater responsibilities: “In a joint stock company you cannot afford stupidity! Managers and the supervisory board have the real responsibility.” (Habicht et al., 2006).

One important aspect of different legal statuses was said to be the perception of the hospital’s ownership. In joint stock companies, the shareholders own the hospital. But a foundation has no owner and only a founder. Even though this mainly seems to be a semantic difference, it may

promote a weaker sense of ownership in a foundation. The weak role and liability of owners (or founders) was one of the problems most frequently mentioned during the interviews (Habicht et al., 2006).

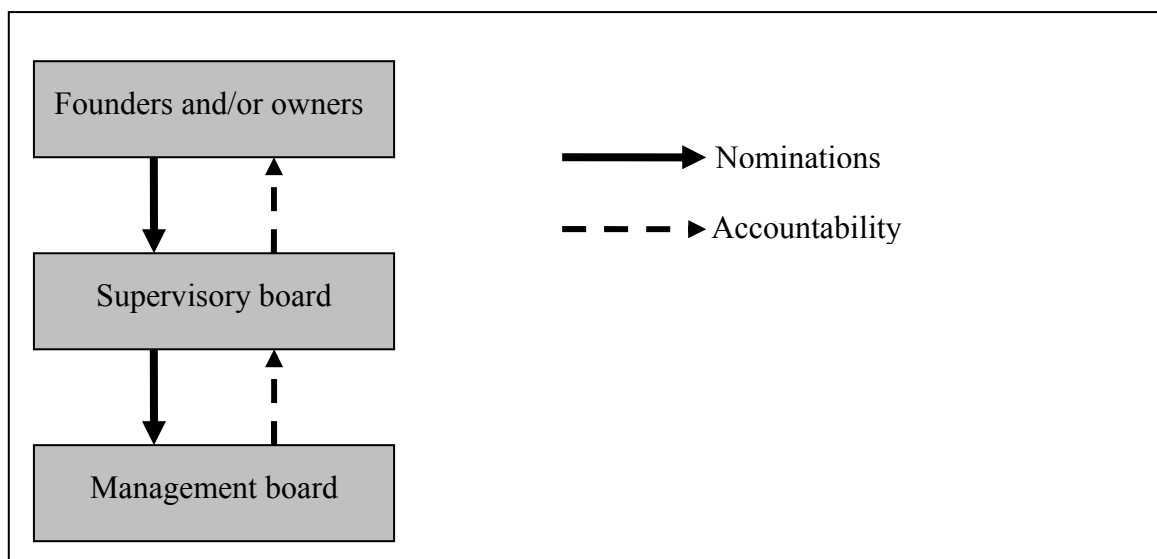
The questionnaire survey carried out among supervisory board members of central and regional hospitals asked them to assess whether they represent the interests of hospital owners. Most (75%) supervisory board members felt that the hospital board to which they belong represents the interest of hospital owners (if a joint stock company) or founders (if a foundation), and only 17% disagreed with that statement; 8% did not know (Habicht et al., 2006).

## Governance structure and mechanism of representation

Before 2002, most public hospitals did not have collective governing bodies. The directors or head physicians were directly subordinated or accountable to the Ministry of Social Affairs or the municipal administration. Hospitals directly subordinated to the Ministry of Social Affairs had for some time an advisory body at the Ministry tasked with supervising all state hospitals – the Supervisory Council of State Hospitals. In reality, the directors of hospitals were very autonomous in their activities, and the supervision of the hospitals was marginal and limited to hospitals seeking investment money from the owner. As an extreme example, one state hospital submitted its budget for review to the Ministry of Social Affairs with expenditure planned to exceed the estimated revenue considerably, without any reaction from the Ministry for several months following the submission (Jesse, 2004).

Today, the organization of hospital governance in broad terms is well defined and transparent (see the governance model in Fig. 5). Both legal types (joint stock companies and foundations) are required to have a supervisory board as a governing body and a management board for operational management. Legislation describes the generic responsibilities of the boards, although in more detail for limited stock companies. The statutes of hospitals, which are approved by the respective owners or founders, further specify the tasks and responsibilities of both supervisory boards and management boards.

Fig. 5. Governance structure of hospitals in Estonia



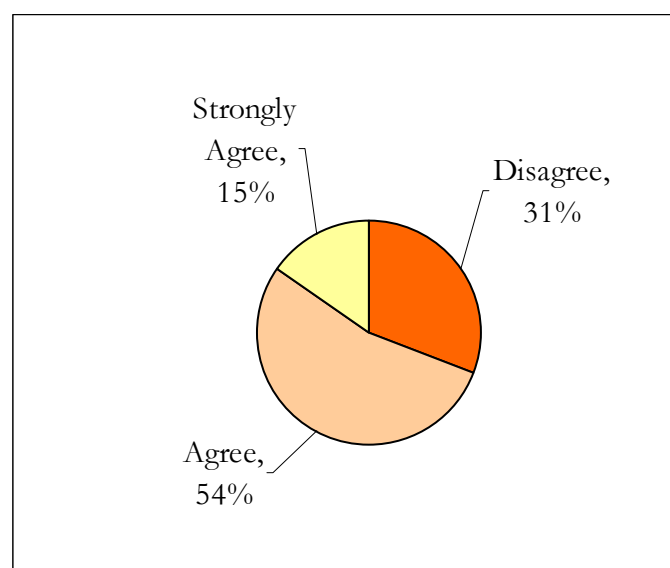
There are no generic or health care-specific legislative requirements related to the appointment of hospital supervisory board members. The supervisory boards of municipal hospitals consist mostly of local politicians (municipal council members), some of whom have a health care background. This does not guarantee that the health care community considers the nominated member competent: “Supervisory board members know nothing about the hospital’s activities (maybe in Tallinn the situation is improving).” In the survey, 69% of hospital managers stated that supervisory boards should be professional rather than political to fulfill the interests of owners or founders (Habicht et al., 2006).

At the same time, the overwhelming view is that the current governance structure inevitably politicizes the supervisory boards to some extent. All the stakeholders have not considered this a problem: “Politicization of supervisory boards is a natural part of democracy.” (Habicht et al., 2006).

For state hospitals, during 2001–2003 the boards consisted mostly of politicians representing the Riigikogu coalition as well as opposition parties and a few civil servants representing the Ministry of Social Affairs. Lately, the political members of supervisory boards have only been affiliated with coalition parties. The political affiliation only with coalition parties has caused changes in the hospital supervisory boards as soon as government coalition changes, thus affecting the continuity of the board’s work. Supervisory boards in Estonia therefore have relatively high turnover. In a postal survey, most supervisory board members (92%) agreed with the statement that supervisory board members change too frequently (Habicht et al., 2006).

Since 2002, the work of hospital boards has become considered to be excessively politicized, mostly in two ways: (a) decisions of public interest that may affect hospital revenues and (b) recruitment decisions for management board positions (Jõgi, 2005; Joosu-Palu & Kaalep, 2002; Kaio, 2006; Maimets, 2005; Olvet & Seaver, 2005; Pärnu Postimees, 2007; Postimees, 2005a,b; Rajalo, 2005). Two thirds of the surveyed hospital managers considered supervisory boards excessively politicized (Fig. 6).

Fig. 6. Share of hospital managers agreeing with the statement: “supervisory board members are excessively politicized in Estonia”.



Source: Habicht et al. (2006).

Regarding the first concern – decisions of public interest – in some cases the supervisory boards have, for example, voted down co-payment schemes proposed by the management board. Hospital managers have attributed this to political interests influencing decision-making, in some cases possibly contradicting the hospital's objectives: "Political decisions may be harmful in economic terms. And sometimes political demands are absurd." (Habicht et al., 2006).

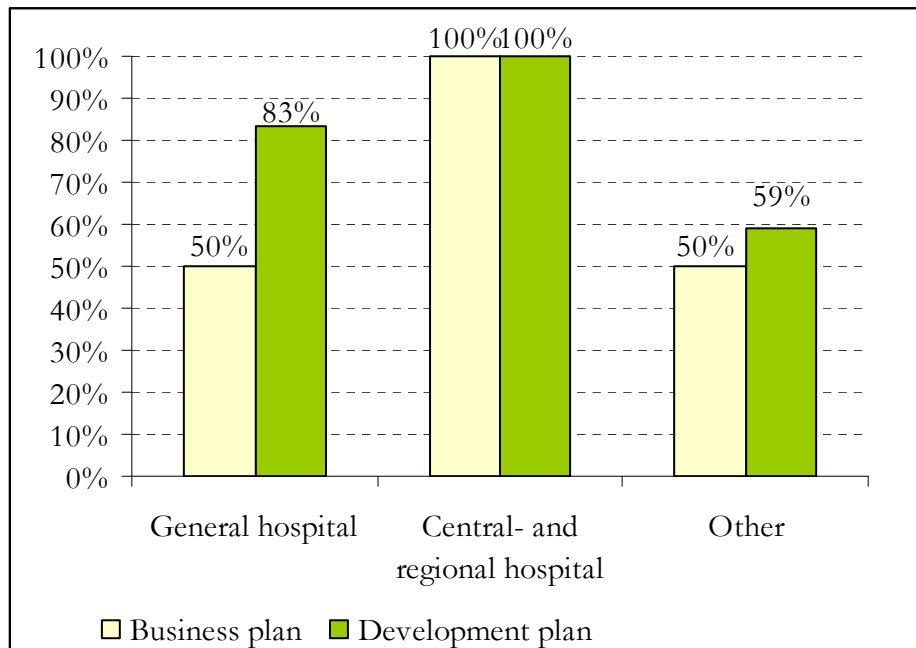
The trend of politicizing personnel decisions, however, constitutes a considerable problem and a risk to hospital performance. In Tallinn municipal hospitals, the chairs of management boards have been changed several times following municipal elections and change in municipal government. Political pressure was also exercised in two other hospitals, one a state hospital, to appoint management board members on political grounds (Jõgi, 2005; Joosu-Palu & Kaalep, 2002; Kaio, 2006; Maimets, 2005; Olvet & Seaver, 2005; Postimees, 2005a,b; Rajalo, 2005). As stated in an interview: "The management board can't do its job, and this may worsen the staff's assuredness, as changes might be harmful." Further, managers might be selected without taking into account competence and experience: "Supervisory board members lack competence and therefore there is no rationality in developing hospital network." and "The supervisory boards should understand that the hospital is a health care establishment, not a place to make politics." (Habicht et al., 2006).

### **Accountability and setting objectives**

Public accountability and accountability within the hospital can be exercised if objectives have been set for the hospital to which hospital managers can be held accountable. Objectives are usually set in accordance with longer-term strategy development, including the wording of the mission and vision statement.

Most Estonian hospitals report that they have a business plan or a long-term development plan (Fig. 7).

Fig. 7. Proportion of hospital managers reporting that their hospital has a business plan or a long-term development plan.



Source: Habicht et al. (2006).

In addition, all hospitals listed in the National Hospital Development Plan should have a functional development plan, which has to be presented to the Ministry of Social Affairs for approval. The Ministry of Social Affairs establishes the requirements for the functional development plan. The important parts of the functional development plan are the needs assessment of the hospital's service area, the situation of infrastructure, planned renovations and the assessment of investment. This functional development plan is mandatory for the hospital but does not exclude the possibility of having other types of development plans that respond to the hospital's needs.

In the assessment of hospital reform in 2006, 79% of hospital managers reported that their hospital has written vision and mission statements. Although all central and regional hospitals reported having written mission or vision statements, in some cases finding the vision and mission statements on their web sites is difficult. Among other types of hospitals, only 53% of respondents from long-term care, rehabilitation and specialized hospitals said that they have some kind of written document on vision or mission (Habicht et al., 2006).

To assess how coherently hospital managers and supervisory board members think of hospital objectives and the extent to which these correspond to national health policy objectives, hospital managers and supervisory board members were asked to rank six most common objectives of the hospital sector according to the priorities of their hospital (Table 2). The results show differences in the priority given to investment in the quality of services and access to care – while supervisory board members see access to care as the most important issue, hospital managers ranked it only as fifth, giving priority to investment in the quality of care. There were no significant differences concerning other objectives.

Table 2. Hospital objectives ranked by importance by hospital managers and supervisory board members

Objectives	Managers	Supervisory board
Ensuring the quality of care	1	2
Improving client services	2	3
Increasing efficiency	3	4
Developing new services	4	6
Improving access to care	5	1
Increasing market share	6	5

Source: Habicht et al. (2006).

The approved strategies and development plans are not always followed, however. When the survey asked whether the supervisory board's decision-making is in accordance with the hospital's mission, vision and long-term objectives, only 54% of the responding supervisory board members from central and regional hospitals agreed to this, 38% held the opposite view and 8% had no opinion. This raises the question of how committed the hospital governors are to the strategy and whether the strategy overall has been developed as a document meant to guide the development of the organization or was solely done to check a box in a list of required documentation. It also raises questions on the applicability of these strategies as an accountability instrument.

When asked about the management board reporting back to the supervisory board on the achievement of the strategy, 70% of supervisory board members reported that this is done regularly, 15% not regularly and 15% no opinion. At the same time, 85% of management board members in general and 91% of central and regional hospital management board members reported that feedback is given to the supervisory board regularly.

Thus, the functioning of supervisory boards and management boards in hospital governance is still in development, and both feel that there is room for improvement. While 38% of management board members feel that the decisions of supervisory boards are not in accordance with the long-term objectives of the hospital, 15% of supervisory board members feel that their reporting on fulfilling the hospital strategy is not sufficient.

## Supervision

Supervisory boards directly oversee hospital activities. The Health Care Board ensures compliance with standards, and the EHIF carries out external supervision related to contractual obligations.

In 2004, the supervisory boards saw their role mainly as controlling the financial sustainability of the hospital and appointing management board members (Jesse, 2004). Other areas such as quality of services and access to services were said to be discussed rarely at board meetings. This finding led to more extensive study of the performance of supervisory boards, including the perception and actual achievement of the roles in the assessment of hospital reform carried out in 2006.

On average, during the past year the responding supervisory board members had participated in board meetings 7 times (minimum 5 times and maximum 12 times). In general, 63% of

respondents were satisfied with supervisory board meetings and 37% were not very satisfied. No respondents considered board meetings very good or very poor. Assessment of the performance of the supervisory board revealed scope for improvement – 62% of the supervisory board members assessed the board’s performance in the past year as being “moderate”, and only 38% as good. Nobody considered the board’s performance to be very good or poor. The results were quite similar for the assessment of their personal performance as supervisory board members – 62% considered their performance moderate, 31% good and 7% poor (Habicht et al., 2006).

Regarding perceptions of the role of the supervisory board, the survey showed that both supervisory board and management board members shared a relatively common understanding: their main functions were considered to be strategy development and supervision of the management board and financial issues (Box 4).

**Box 4. The roles of supervisory boards mentioned by supervisory board members**

1. Strategy building (62% of respondents)
  - “To empower managers to think what to do to ensure the hospital’s sustainable development in the shorter and longer term”
  - “To set strategic objectives for the hospital”
  - “Strategic planning”
  - “Mission statement and strategy development”
  - “Development plans to serve the population”
  - “To develop the precise scorecard for managers”
2. Budget and financial issues (54% of respondents)
  - “To monitor the budgeting issues”
  - “Budget”
  - “Economic decisions in providing health care services”
3. Supervision of the management board (31% of respondents)
  - “To ensure the sufficiency of supervisory mechanisms”
  - “To supervise the achievements in terms of set objectives”
  - “To monitor the scorecard”
4. Other frequently mentioned roles of supervisory boards
  - “To represent the interests of owners and main clients – patients”
  - “Not to obstruct managers’ sound initiatives”
  - “To control the activities and to not let managers decide by themselves. Supervisory board should not worry about the profit”
  - “Balanced provision of health care services”
  - “To participate in negotiations with the EHIF, especially the Ministry of Social Affairs”
  - “Balanced development of staff”
  - “Qualification of health workers and their economic goodwill”
  - “Selection of managers”
  - “Good cooperation with managers”
  - “Good cooperation between supervisory board members”

Source: Habicht et al. (2006).

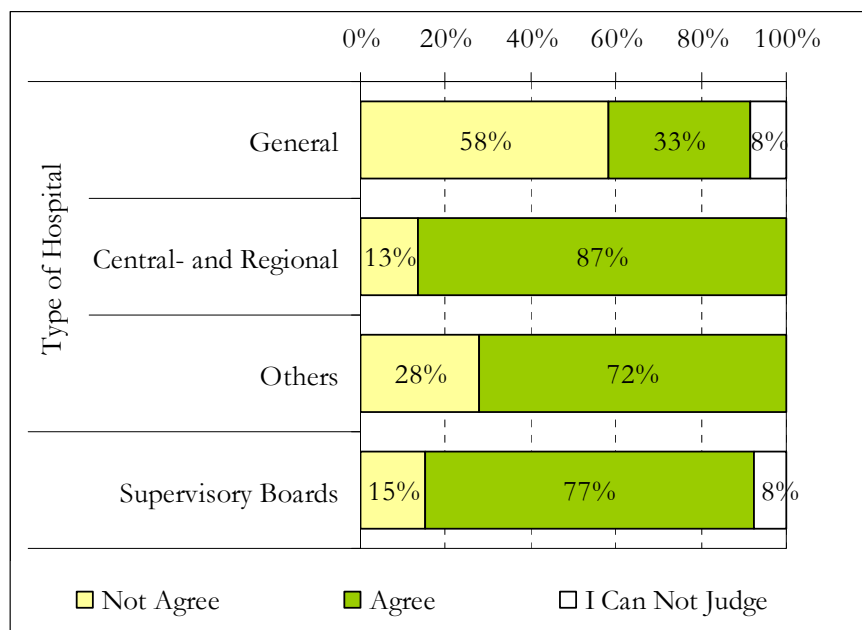
In addition to the these functions above, the management board members also saw the supervisory board’s role in acquiring financial resources, lobbying, representing the hospital and cooperating with politicians and owners, including at the national and regional levels.

Some respondents viewed the role of supervisory boards as a distant hands-off role, such as “Not to disturb managers”. This may be due to some instances of strong intervention perceived not to

be in the best interest of the hospital, such as supervisory board members with a political mandate influencing the selection of management board members (Habicht et al., 2006).

Overall, the supervisory board members felt that they were more significant in decision-making than the hospital managers do – while 77% of the supervisory board members felt they significantly influence managers’ decisions, only 67% of hospital managers agreed with this statement. This was different for central and regional hospitals, however, where the managers considered the supervisory board role to be stronger (87% of managers think that the supervisory board has a significant role) than managers of general hospitals (Fig. 9).

Fig. 9. Share of hospital managers and supervisory board members agreeing with the statement: “the hospital supervisory board at your hospital significantly influences the hospital’s management”.



Source: Habicht et al. (2006).

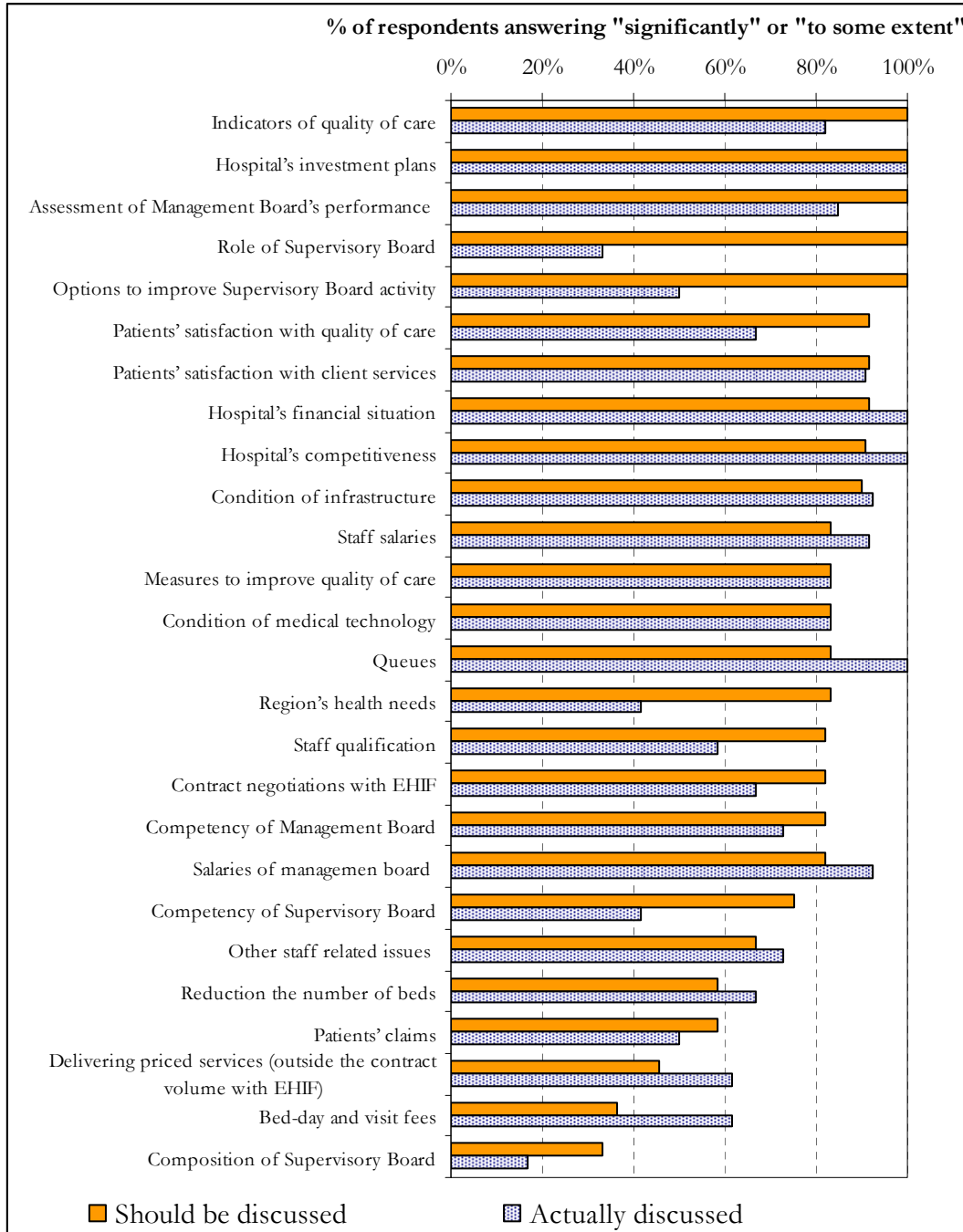
Most supervisory board members (69%) thought that the supervisory board should have a greater role. The interviews also showed that the supervisory boards have acquired a more important role over time, with interviewees admitting that the supervisory board’s role was minimal in the beginning in 2002–2003: “In the beginning, the management board managed the supervisory board, too ...”. In an interview, one manager had the following interpretation of “good performance” of the supervisory board: “The supervisory board’s performance is good and they haven’t disturbed the hospital’s development.” (Habicht et al., 2006).

The survey asked supervisory board members to assess to what extent various topics (Fig. 10) were discussed in supervisory board meetings during the past year and the extent to which the supervisory board should discuss these topics.

The most important topics that the supervisory board should consider important agenda items are the quality of care, the hospital’s investment plans and aspects related to the supervisory board such as their role, performance and options for improvement. The gap between the desirable and actual situation was assessed to be widest for issues of the role of the supervisory board (actual and ideal situations differed by 67%), options to improve supervisory board activity (difference

50%), the region's health needs (difference 42%) and the competence of the supervisory board (difference 33%).

Fig. 8. Assessment of topics needed to be discussed and actually discussed by the supervisory boards.



Source: Habicht et al. (2006).

Question posed to supervisory board members: "to what extent should the supervisory board discuss the following topics in their meetings, and to what extent have they actually discussed this?". There were five response options: significantly, to some extent, not much, not at all, I cannot judge. The figure shows the proportion of respondents reporting that the topic should be (and has been) discussed significantly or to some extent. The results are ranked according to the

topics that should be discussed in supervisory board meetings, and the gap between two bars shows the difference between the ideal and actual situations.

In external supervision, the role of the Health Care Board in supervising the hospital is related to checking compliance with licensing criteria and other regulated requirements. The Health Care Board also processes complaints and carries out related supervision. The Health Care Board has the right to revoke a licence from the provider if deficiencies are found.

## **Reporting requirements**

The hospitals report health care statistics to the Ministry of Social Affairs (National Institute for Health Development from 2008). Financial reports are submitted to hospital supervisory boards and owners and, for joint stock company hospitals, also to the Commercial Registry.

Hospitals included in the National Hospital Development Plan are required to submit their budgets and annual reports to the Ministry of Social Affairs, which are published on the Ministry's web site.

## **Auditing requirements**

As legal entities, hospitals are required to be audited annually by an independent auditor. In addition, the National Audit Office has the right to conduct financial as well as performance audits in hospitals founded or owned by the state.

Under contract with the EHIF, the hospitals are also required to participate in medical audits conducted or commissioned by the EHIF.

## **Effects of the hospital governance mechanisms on health system performance and attaining health system goals**

The current governance mechanisms in the hospital sector were introduced as part of a corporatization process from 2001 onwards. Until 2001, the hospitals operated as general partnerships, limited partnerships, private limited companies, public limited companies, commercial associations, foundations, not-for-profit associations as well as some as state or municipal agencies, and the extent of variation also meant great variety in supervisory structures and in accountability mechanisms. The transformation process into foundations or joint-stock companies revealed that the oversight by owners over hospital activities had been quite limited: some hospitals were in a difficult financial position and some assets could not be accounted for.

The establishment of supervisory boards, which are responsible for overseeing hospital performance, strengthened oversight and increased the transparency of hospital activities. The collective decision-making both in supervisory boards and management boards has decreased the risk of negligence or of undue risk-taking in hospital management, which can happen more easily with only one or two people making decisions. Not surprisingly, the supervisory boards and management boards were initially more focused on economic issues to get the hospitals into a sound and sustainable financial position.

The survey among the supervisory board members indicates that they generally understand that the role of hospital boards extends beyond solely being accountable for the hospitals' finances and that they also have to take responsibility for access to services, quality of health services and other issues.

The actual discussion of these issues, however, has been limited, perhaps due to informational asymmetry in health knowledge, which often makes supervisory board members who have no health care background uncomfortable in relation to issues of quality of and access to health services.

In many instances, the performance of the supervisory board is considered to be weakened by high turnover among the members, mostly due to political changes. Very worryingly, some management board members have been nominated as a result of political negotiations rather than based on professional merit. Both these phenomena undermine the authority of supervisory boards among the staff of the hospitals.

Overall, the current governance arrangement in the hospital sector contributes greatly to ensuring the sustainability of hospitals and therefore the health system as a whole, as hospitals form a significant part of the health system.

On the financial protection of the population, the supervisory boards influence co-payments and privately paid services in the hospital sector. As the boards of public hospitals consist mostly of politicians with political accountability, co-payments have sometimes been cut back or approved at a lower rate than initially proposed by management boards, resulting in lower out-of-pocket expenditure and therefore increased financial protection for patients.

Regarding responsiveness, the current mechanism has the potential to improve the client service side of hospitals as well as access. This would require, however, empowering supervisory boards to expand their role and to increase the capacity to discuss these topics.

## **Conclusions and recommendations**

The current hospital governance mechanism through supervisory boards has been in effect since 2001, and it is clearly still being developed. Although it has already demonstrated improvement from the previous situation in assuring financial soundness and transparency, the boards rightly feel they should address hospital performance from all aspects, including access to services and the quality of health care. This requires improving the supervisory boards' authority and competence (Tsolova et al., 2007).

To improve the competence of supervisory boards, the Ministry of Social Affairs may consider providing training (perhaps mandatory) for supervisory board members to improve their competence.

Excessive politicization of the membership of supervisory boards is considered a risk to the boards' performance related to the continuity of work and due to the risk of political influence on recruitment decisions for managerial positions.

To balance political representation and improve continuity, the boards of public hospitals could comprise all the parties represented in the respective elected organs (the Riigikogu for state

hospitals and the municipal council for local hospitals). Political risks can be diminished and board competence increased by issuing guidelines for developing a code of conduct for supervisory board members, which helps to determine the hospital's culture. Including private-sector representatives on supervisory boards would draw on private-sector management experience to improve hospital performance.

Estonia's hospitals have started to participate in performance assessment projects, and the Ministry of Social Affairs and EHIF need to further encourage and support this. A culture of regular performance monitoring would provide a mechanism for aligning system-level objectives with institutional objectives.

## References

1. EHIF (2006). Eesti Haigekassa arengukava 2006-2008 [EHIF Development Plan 2006–2008]. Tallinn, Estonian Health Insurance Fund.
2. EHIF (2007a). Eesti Haigekassa arengukava 2007-2009 [EHIF Development Plan 2007–2009]. Tallinn, Estonian Health Insurance Fund.
3. EHIF (2007b). Eesti Haigekassa Nõukogu otsus nr 21 Eesti Haigekassa juhatuse esimehe ametilepingu põhitingimused ja nr 26 Eesti Haigekassa juhatuse liikmete ametisse nimetamine, nende ametitasude ja ametilepingute põhitingimuste kinnitamine [Supervisory Board Decisions no. 21 and 26 on approval of Management Board members' contracts]. Tallinn, Estonian Health Insurance Fund.
4. Fidler A et al. (2007). Incorporation of public hospitals: a “silver bullet” against overcapacity, managerial bottlenecks and resource constraints? Case studies from Austria and Estonia. *Health Policy*, 81:328–338.
5. Government of Estonia (2007a). Programme of the Coalition for 2007–2011. Tallinn, Government of Estonia (<http://www.valitsus.ee/?id=1468>, accessed 20 May 2008).
6. Government of Estonia (2007b). Arengukavad [development plans] [web site with all Government approved development plans]. Tallinn, Government of Estonia (<http://www.valitsus.ee/?id=5226>, accessed 20 May 2008).
7. Habicht T, Aaviksoo A, Koppel A (2006). Hospital sector reform in Estonia: summary. Tallinn, PRAXIS Center for Policy Studies ([http://www.praxis.ee/data/Hospital\\_sector\\_reform\\_in\\_Estonia\\_final\\_cover.pdf](http://www.praxis.ee/data/Hospital_sector_reform_in_Estonia_final_cover.pdf), accessed 20 May 2008).
8. Habicht T (in press). Governing a single-payer mandatory health insurance system: the case of Estonia. In: Savedoff WD, Gottret P, ed. *Governing mandatory health insurance: learning from experience*. Washington, DC, World Bank.
9. Hellers G et al. (2000). The Estonian Hospital Master Plan 2015. Consultant report by SC Scandinavian Care Consultants AB and SWECO International AB for Estonia's Ministry of Social Affairs.
10. Government of Estonia (2003). Haiglavõrgu arengukava: Vabariigi Valitsuse 2. aprilli 2003. a määrus nr 105 [Hospital Network Development Plan: Government Decree no. 105 of 2 April 2003]. Tallinn, Government of Estonia (<https://www.riigiteataja.ee/ert/act.jsp?id=560288>, accessed 20 May 2008).
11. Jesse M (2004). Early assessment of hospital mergers in Estonia. Unpublished.
12. Jesse M et al. (2004). Health care systems in transition: Estonia. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004 ([http://www.euro.who.int/InformationSources/Evidence/20011015\\_2](http://www.euro.who.int/InformationSources/Evidence/20011015_2), accessed 20 May 2008).
13. Kaio H (2006). Kuidas parteid uusi haiglaid ehitavad [How the parties build new hospitals]. *Eesti Ekspress*, 9 November (<http://paber.ekspress.ee/viewdoc/C57802F4C6B75D6FC225721F004920DA>, accessed 20 May 2008).
14. Koppel A, Aaviksoo A (2007). Performance assessment tool for Estonian hospitals. *Health Policy Monitor* (<http://www.hpm.org/survey/ee/a10/2>, accessed 20 May 2008).

15. Jõgi A (2005). Haigla eksjuht: poliitikat liiga palju [Former hospital manager: too much politics ]. Eesti Päevaleht, 30 June.
16. Joosu-Palu T, Kaalep T (2002) Erakondlik klistiir [A party enema]. Eesti Ekspress, 13 February, (<http://paber.ekspress.ee/viewdoc/00FC6496CDF854D842256B5F003510EA>, accessed 20 May 2008).
17. Maimets A (2005). Tallinna võimuliit tahab loobuda keskerakondlikust haiglajuhist [Coalition in Tallinn wants to get rid of a centrist hospital manager]. Postimees, 24 January (<http://www.postimees.ee/240105/esileht/155897.php>, accessed 20 May 2008).
18. Ministry of Social Affairs (2007). Rahvastiku Tervise Arengukava [draft National Health Strategy]. Tallinn, Ministry of Social Affairs, 2007 (<http://www2.sm.ee/tervisepoliitika/index.php?id=491>, accessed 20 May 2008).
19. National Audit Office of Estonia (2007). State supervision over health care providers. Does supervision support provision of high quality health services? Report of the National Audit Office to the Riigikogu, September 13, 2007. Tallinn, National Audit Office of Estonia ([http://www.riigikontroll.ee/fake\\_index.php?lang=en&uri=%2Faudit\\_en.php%3Flang%3Den%26audit%3D507](http://www.riigikontroll.ee/fake_index.php?lang=en&uri=%2Faudit_en.php%3Flang%3Den%26audit%3D507), accessed 20 May 2008).
20. Office of the Minister for Population and Ethnic Affairs (2004). Rahvastikupoliitika aluste elluviimise strateegia [Population strategy 2005–2008]. ([http://www.valitsus.ee/failid/Rahvastikupoliitika\\_aluste\\_elluviimise\\_strateegia\\_2005\\_2008.pdf](http://www.valitsus.ee/failid/Rahvastikupoliitika_aluste_elluviimise_strateegia_2005_2008.pdf), accessed 20 May 2008).
21. Olvet T, Seaver S (2005). Res Publica kangutab reformerist haiglajuhti [Res Publica levers reformist hospital manager]. Postimees, 6 May (<http://www.postimees.ee/070505/esileht/siseuudised/tallinn/165004.php>, accessed 20 May 2008).
22. Pärnu Postimees (2007). Külvar Mand tagandati Pärnu haigla juhatusest [Külvar Mand was dismissed from Pärnu Hospital Management Board ]. Pärnu Postimees, 30 March (<http://www.parnupostimees.ee/300307/esileht/10073345.php>, accessed 20 May 2008).
23. Põlluste K et al. (2006). Quality improvement in the Estonian health system – assessment of progress using an international tool. Journal for Quality in Health Care, 18:403–413.
24. Postimees (2005a). Juhtkiri: poliitkarussell haiglates [Editorial: political carousel/merry-go-round in hospitals]. Postimees, 24 January (<http://www.postimees.ee/240105/esileht/arvamus/155890.php>, accessed 20 May 2008).
25. Postimees (2005b). Ka Põdder sai ametisse võimu vahetudes [Põdder gained office also by power changes]. Postimees, 24 January (<http://www.postimees.ee/240105/esileht/siseuudised/155903.php>, accessed 20 May 2008).
26. Rajalo P (2005). Pärnu arstid kardavad poliitikutest haiglajuhte [Pärnu’s doctors fair political hospital managers]. Postimees, 15 September (<http://www.postimees.ee/150905/esileht/siseuudised/177070.php>, accessed 20 May 2008).
27. Riigikogu (2000). Estonian Health Insurance Fund Act. Tallinn, Estonian Health Insurance Fund, 2000 (<http://www.haigekassa.ee/eng/legislation>, accessed 20 May 2008).
28. Tsolova S et al. (2007). Hospital reform in Bulgaria and Estonia: what is rational and what not? Final report. Budapest, Local Government and Public Service Reform Initiative, Open Society Institute ([http://lgi.osi.hu/publications\\_datasheet.php?id=369](http://lgi.osi.hu/publications_datasheet.php?id=369), accessed 20 May 2008).

29. Veillard J et al. (2005). WHO mission to Estonia – assessment of hospital reforms: August 29 – September 2, 2005. Copenhagen, WHO Regional Office for Europe, 2005 (<http://ee.euro.who.int/HospitalReportEstonia.pdf>, accessed 20 May 2008).
30. World Bank (2007). Governance matters 2007. Worldwide governance indicators, 1996–2006 [database]. Washington, DC, World Bank (<http://info.worldbank.org/governance/wgi2007>, accessed 20 May 2008).