Reforms in the Hospital Healthcare System in Macedonia, Estonia and Hungary

An overview of the implemented reforms, the reactions from stakeholders and evaluation of policies

Introduction

The aim of this study is to explore healthcare reforms of the public health system in Estonia, Hungary and Macedonia in terms of changes in the level of corporatization, autonomization and decentralization of the health care sector – commonly denominated as New Public Management (NPM), within the period of most recent and intensive reforms for each respective country. The study at hand consists of three individual country reports which reflect and assess the reforms which were implemented within their respective national contexts. Each of the reports, firstly provides an overview of the reforms implemented, while also assessing how these reforms fit within the NPM paradigm. Subsequently, each country report explores the effects of the reforms on health care employees and whether the changes had triggered some kind of collective responses by labor unions and the general public. Each country report concludes by highlighting the potential impact of employees and the public’s reaction in shaping the course of healthcare sector reforms and in the quality of health services in general. Finally, this study concludes with a comparative overview of the general trends in healthcare reforms in all three countries as representative of post-socialist transitioning states.

Methodology

Reforms in health care sectors were traced by sector-specific government programs and changes in the related legislation. Reaction of employees and the public were mapped through daily news and other media sources, surveys and opinion polls, as well as written declarations and petitions of labor unions and other related employee associations and patients’ representatives. Main statistical indicators to assess how the changes affected the variables of health care service provision are number of doctors per habitants, number of active beds in hospitals per habitants, and service user satisfaction surveys. These indicators should offer the possibility of comparability among countries in the region which underwent similar processes.

However, an important note of consideration should be made regarding the limitations of this study. These limitations might arise due to the fact that only materials that were available online have been used and not all of the reforms implemented within the 2011-2014 project have been considered – both due to their quantity and inaccessibility of the relevant materials online.
Reforms in the Hospital Healthcare System of Estonia

Today the Estonian health insurance system is based on universal coverage and is mandatory for everyone, thus covering about 95% of the population. Ministry of Social Affairs is responsible for financing emergency care for the groups that are uninsured ((EC) 2014). The implementation of reforms has been steady and balanced, and surveys conducted among users have consistently shown high marks of assessment of quality. However, the accessibility of healthcare services is still a problem, mostly because services at specialists’ departments are relatively slow and patients wait for long.

The timeframe of hospital healthcare reforms in Estonia

The history of the Estonian health care reforms can be divided into three periods: the beginning of the 1990s, mid 1990s and the beginning of the 2000s. It is divided like this because the most influential reforms on which the Estonian health sector is based were implemented in these periods.

Beginning of the 1990s

The reforms in the beginning of the 1990s are best characterized by trying to build up the entire Estonian health care system that was thus far ineffective. According to Hsiao and Nicolae, the Estonian health care system before independence (1991) was based on the Soviet Semashko model, which meant the health care system was highly centralized and was financed through state revenues. Moreover, in the beginning of the 1990s, the Estonian health care sector was underfunded, the total health expenditure from GDP was about 4,3% (1992) compared to the EU average the same year that was 7,8% (Hsiao 2009). Although health care was supposed to be free and accessible to everyone, the insufficient health funding still meant that the depth of coverage varied (ibid). Moreover, the authors point out that the hospitals were poorly planned in terms of both maintenance and human resource management and supply. For example, the clinical practice and technologies were far behind Western practices and, on the one hand, there was an excess of specialists like pediatricians, but an insufficient supply of nephrologists (ibid: 2). The goal of the health sector reforms was easily identifiable: to make this sector more effective.

Estonia initiated its major health care reforms in 1991, although the preparations started already in the 1980s and were supposed to bring radical changes too, but due to short deadlines they were not implemented (Hsiao 2009, 3). According to the Joint Learning Network for Universal Health Coverage (JLN) in 1991, the Health Insurance Act was passed in Estonia and in 1994, the Health Services Organization Act, which provided the framework for the reforms that followed. Foremost, the health financing system was transformed from a centralized to a decentralized social health insurance model and 22 non-competing funds were established in Estonia that were coordinated through the Association of Sickness Funds ((JLN) 2014).
What is also important is that from 1992, when the health insurance system was introduced together with the establishment of autonomous providers, health care employees ceased to be public servants and started working under private labor regulations (Koppel 2008, 151). Moreover, a 13% health insurance tax was established in order to provide for financing of the healthcare sector (Sinisalu 2007, 428-430). At first the health insurance tax was a separate tax, but in 1994 it was incorporated into the social tax that employers need to pay (Koppel 2008, 181). A total of 22 regional sickness funds collected the health insurance tax. However, additional insurance was made available for cases that were not covered by the state-provided insurance (Koppel 2008, 181).

According to the European Commission (EC), the reasons for the reforms in the beginning of the 1990s (that most essentially established the basis of Estonian health care system) were the following:

- to ensure a sound revenue base for the health care system;
- to connect and bring closer together the health insurance and labor market (EC 2014)

Additionally, mandatory insurance presented an incentive to participate in the formal labor market (ibid). However, the EC also highlights that this kind of reform had several negative effects and the main drawback was that the low level of training of health insurance employees, which was mainly because of lack of experience and the non-existent availability of courses (ibid).

**Reforms from the mid-1990s**

Further, the reforms in the health sector were best characterized by reducing the amount of hospitals and further developing family medicine.

The hospital network was reduced by the Estonian Hospital Masterplan 2015 that meant 1993-2001 the amount of hospitals was reduced from 115 to 67, hospital beds from 14,400 to 9,200 and in addition, the average stay in hospital for the patient declined from 15.4 to 8.7 days (Atun 2006, 83). This was accompanied by the fact that the primary health care (PHC) experienced a big rise in consultations, from 2.57 million in 2000 to 3.94 million in 2003 (ibid). Moreover, according to Atun et al., Estonia was the first country among the post-Soviet countries where family medicine (FM) was designed as a specialty. This meant a three-year long residency programme for new graduates was introduced.

In the mid-1990s, the groups eligible for health insurance without contribution were more clearly defined, thus giving an incentive to working age population to participate in the formal labor market (Koppel et al., 2008: 184). However, in 1995 the co-payments for the primary care and specialist visits were established with the goal of increasing revenues for the health sector (EC 2014). Considering that the public was previously used to access to free healthcare, this reform was deemed unpopular (ibid).
In 1997, the family medicine was developed to the level that the changed health service regulation demanded that Estonian citizens register themselves with family physicians who were supposed to provide PHC to their registered population (Atun 2006, 83). In addition, from 2002, the tripartite polyclinic structure (women, children and men were provided services separately) were changed in that family physicians took all the patients irrespective of their age and gender (ibid).

Moreover, overall regulatory frameworks were provided for health financing, health care providers and pharmaceuticals (Koppel 2008, 189). Between 1997-1999 many additional regulations were implemented in different areas of the health sector (ibid). In this sense, it was a time of making more clear what role the different actors in the health sector had and how it was regulated.

Reforms from the beginning of the 2000s

In the beginning of the 2000s, the main themes of reforms in Estonian healthcare were further developing the existing system and the most important institutional reform was creating the Estonian Health Insurance Fund (EHIF).

In 2000, the Estonian Health Insurance Fund was established and immediately became the main health service public purchaser and administrator of the country's health system (Hsiao 2009, 9). As appendix 1 shows, among other competencies, the EHIF has the power of contracting providers and paying sickness benefits to insured people. Thus, it can be stated that the EHIF is the most important and central actor in the Estonian health care system.

The Health Services Organization Act of 2002 set up the regulatory framework for primary care and family medicine in Estonia (Koppel 2008, 144). As mentioned before, this meant that every family doctor had their own service area and these family doctors are established as private contractors, contracted by the Estonian Health Insurance Fund (EHIF) (ibid). According to Koppel et al., A peculiar element in the case of Estonia is that hospitals are still preserved in public ownership, but use the management concept of the private sector. This practically means that the hospitals are mainly owned or funded by the state, local governments or public local bodies and the hospitals have a private legal status (Koppel 2008, 153-154).

In 2001, a new governance structure of the hospitals was established: a 2-tier management with supervisory and management boards (ibid: 154-155). This reform was a movement towards the principle of corporatization in the health system. However, even though corporatization is often followed by privatization, this never happened in Estonia and the hospitals remained joint stock companies of the state and local governments1.

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1 For the overview of the Estonian health care system, see Appendix 1.
Lai et al. Point out that with the health system reforms of 2000-2002 a legislative background for a market-like environment was created in the healthcare system. This meant that the hospitals’ managers felt they were competing for the EHIF contracts that led to many investments into services that were favorably priced by the EHIF and this most directly led to a large duplication of services where the hospitals tried to cover the full spectrum of services (Lai 2013, 20). In this sense, they were like competing companies according to the marketization principles. However, this had more negative than positive effects.

After that, the biggest major reform in Estonia was adopting the National Health Plan 2009–2020 (NHP) in 2008 (Lai 2013, 22), the goal of which was basically to increase the number of healthy lived years of the population and reduce mortality and morbidity rates (ibid: 161). Moreover, they list five areas that they focus on:

- increasing social cohesion and equal opportunity;
- ensuring the healthy and safe development of children;
- developing a health-supportive environment;
- promoting healthy lifestyles;
- securing the sustainability and quality of health care (ibid).

After the NHP reform, no other major reforms have been done in the Estonian health care sector.

![Figure 1: Overview of the Estonian Health Care System (Estonian Health Insurance Fund 2014)](image)

**E-health reforms**

The introduction of the e-health reforms in principle are not new reforms, but they target making service delivery more effective. The most well-known changes that have been implemented in recent years have been
the Electronic Health Record, Digital Registration, Digital Image, and Digital Prescription (E-Health, National eHealth projects 2012). The goal of the Electronic Health system, the idea of which came already in 2002, was to improve the exchange of medical documents that were previously only available in local databases (E-Health 2014). With digital description that was launched in 2010, it is possible for doctors to prescribe medicine online to patients and this information would be accessible in all the pharmacies (EHIF, Digital prescription 2014).

According to the National Audit Office of Estonia (NAOE), digital registration was supposed to be a central system where a patient can pick suitable times for doctors in any hospital and digital image was supposed to be a big database where all the medical images are stored. However, although 15 million euros has been spent on these e-health solutions so far, medical prescriptions system is the only solution that is currently effectively working (NAOE 2014). The reason for this is believed to be the bad coordination in the field of development and implementation of e-health services by the Ministry of Social Affairs (ibid).

Reactions of Stakeholders

A. Reaction of the health employees to the reforms

Negotiations before 2012

The Estonian context saw not many protests regarding the healthcare reforms themselves. However, the rise of resentment is mainly connected with the low salaries of the healthcare employees and the accessibility of the healthcare. For example, in 2001, the Estonian Medical Association stated that it was unclear who was at that moment leading the healthcare reform and many vital questions such as funding still remained unanswered ((EMA) 2001). This meant that there was no firm plan on how to reform the healthcare sector and this confusion could lead to a confrontation between patients and doctors over issues for which the doctors are not responsible (ibid).

In 2002, the Estonian Nurses Union started to strike because the Hospital Association did not want to negotiate with them on the terms of the minimum wage and, together with the Estonian Medical Association, they achieved a double increase of the minimum wage for the nurses and carers (Koppel 2008, 31). The reason for this can be traced to the fact that the negotiations over the minimum salary of nurses that were initiated as early as 1996 had still not yielded any results (Heinla 2000). Thus, the Estonian healthcare is characterized by long wage negotiations. For example, although the negotiations started in the mid-1990s over the minimum wages of the healthcare sector, the first agreement was achieved as late as 2002 (Rehemaa 2004, 641). According to Rehemaa, in 2004 the wage negotiations continued with the help of the official mediator and the result was that the health sector employees were offered a salary increase in 2005 that would be frozen after that for two years. However, this did not satisfy the health employees because the budget allocated to healthcare was deemed too low. For example, in 2003 it was less than 5% of GDP, making this the lowest
contribution among the EU member states, as the spending tendency was decreasing even further (ibid: 641-642).

The tensions about low salaries of health care workers accumulated and this led to the result that in the beginning of 2007, the health sector employees declared a general strike that was supposed to start on the 17th of January 2007 ((EMA) 2001). In their press release, the reason for this was increasing the salaries of the healthcare sector generally and the fulfillment of the 2004 wage agreement that among others determined higher minimum salaries - but this had not been fully fulfilled by the state (ibid). However, the strike itself did not happen in the end. With the negotiations, the necessary funding for the health sector was found and a new collective contract that established new minimum salaries was concluded (Laasik 2012). However, many tensions related to this led to a new strike 5 years later.

The 2012 general strike

The tensions grew and in 2012 the biggest medical employees strike in Estonia took place. However, now the focus shifted from salaries to the big workload, small salaries of the nurses and caregivers and the big extra amount of work in several hospitals that meant the medical employees needed to make much overwork in order to earn extra revenues (Laasik 2012). The strike itself started on 1 October 2012 and was attended by most of the doctors who were able to participate ((ERR) 2012). In the North Estonian Medical Centre, which is the biggest medical center in Estonia, 170 out of 210 doctors who had reception times were on strike. Thus, appointments were only provided for people under the age of 18 years, for pregnant women, people who needed oncological treatment and for those who were in need of emergency medicine (ibid).

Iivi Luik, who is the President of the Union of Estonian Healthcare Professionals, stated that the goal of the strike was signing a new collective agreement that they could treat the patients in Estonia (referring to the big departure of Estonian medical workers from the country), while at the same time earning a decent salary and having a normal working load (EMA2, Toetusavaldused 2012). Although the negotiations started almost immediately after the strike, the solutions did not come so easily. Thus, a week later the strike expanded and besides the four biggest hospitals that were on strike, hospitals in the smaller cities like Pärnu, Kuressaare and Viljandi ja Narva also joined the strike by refusing to take patients to their routine receptions (Delfi2 2012). Moreover, two smaller hospitals made a token strike and the strike expanded to surgery related departments that meant many operations were cancelled (ibid).

On the 12th of October, almost two weeks after the beginning of the strike, it seemed that an agreement could be still made. However, the healthcare workers refused to end the strike before the agreement itself was signed, so after many rounds of negotiations, the strike finally ended after 25 days (Delfi3 2012). According to the new agreement, the residents started earning full salaries and the workload of doctors and nurses was
reduced by 20% in the ambulant and 14% in their stationary work (Delfi (4) 2012). Moreover, the minimum salaries of caregivers, nurses and doctors were raised by 23%, 17.5% and 11%, respectively (ibid).

This agreement ended the longest strike in the history of Estonia, where the work of the entire health sector was heavily disrupted.

B. Reaction of the general public

The 2012 strike was one of the most covered strikes in the media so far. Various opinion leaders, high officials and healthcare workers produced numerous articles on the topic. Moreover, the Estonian biggest news portal delfi.ee and the biggest newspaper, Postimees, had a special blog dedicated to the strike, where the developments were reflected on an hourly basis. Since strikes are not a commonly used tool in the negotiations of collective agreements in Estonia, this event was of a historical significance.

However, the unrest on the side of medical professionals was not accordingly reflected by the public opinion. During the strike of the healthcare associations, whose membership counts more than 17,000 members, a large number of public organizations announced their support for the strike (EMA2, Toetusavaldused 2012). On the 18th of October, a press release was posted on the Estonian Medical Association web page, stating that 35 organizations announced their support for the strike (ibid). In general, it was a selection of many different organizations, among which were numerous schools, the Estonian Teacher’s Association and different opposition political forces (ibid).

On the other hand, Estonia’s most important business newspaper Eesti Äripäev, for example, condemned the strike, considering it cynical that the unions were trying to achieve their goals via a strike (Äripäev 2012). In their press release, they stated that although they agreed that the salaries of the doctors and nurses should rise, the same applies among others such as teachers, police officers and rescuers (ibid). Moreover, they stated that in 2006 the doctors had a rise in salary of 25% and another 20% in 2007, which was higher than in any other sectors. They also stated that while the main goal of the strike was to increase the salary of the medical sector workers, strikers should be aware that that Estonia is not Sweden or Finland that could afford to have such big salaries (Äripäev 2012). To conclude, the main reason why public opinion was in some cases cautious in supporting the strike of the doctors, was that the salary of the doctors is already much higher compared to the other public sector employees (for example teachers).

During the strike, the news portal Delfi made a public poll, asking the readers how justified the strike was. From the 2163 answers, 50.3% of the respondents found that the strike was unjustified and 49.7% of the respondents thought that the healthcare workers were right to strike. The pro arguments that the readers made were mainly connected with the low salaries of nurses and caregivers (who can earn as low as 300 euros)
and reducing their workload (Delfi 2012). On the opposing side, it was highlighted that this strike was a deception for people who were in need of medical assistance (ibid).

The most frustrated were patients whose medical appointments were cancelled. For example, in Postimees, a reader of the newspaper Evelin complained that her three admissions during the strike were cancelled and this strongly affected her life. Other patients also mainly brought forth the frustration that their appointments with medical specialists, whose waiting lists are already long, were again postponed for several months (Postimees 2012). On the other hand, supporters of the strike said that their life was not affected by the strike and the necessary services were still covered by family doctors who were not fully participating in the strike (ibid).

In this sense, public opinion had mixed perceptions about the healthcare workers’ strike. Many organizations from different spheres of life supported it, but many people were also disappointed with the cancellation of appointments and felt that the doctors already had high salaries compared with the Estonian average.

C. The satisfaction with healthcare in Estonia

Except for the great strike in 2012, there has not been a significant resentment towards the reforms in the health sector in Estonia. One of the first opinion polls over patients’ satisfaction with healthcare services quality was conducted in the year of 2000 by the research company TNS EMOR. According to the survey, the majority opinion was that the people were in overall satisfied with the healthcare service, but they would expect a more caring attitude from the doctors. Tiina Juhansoo, who teaches medical ethics at the University of Tartu has justified the lack of caring by the fact that medical workers see death every day and they are used to it, whereas for ordinary citizens it has another meaning (EMOR 2000). However, Estonians were satisfied with the quality of healthcare and the lack of caring attitude from the healthcare workers has not been mentioned in the latter public opinion studies.

Fortunately, regular surveys over the quality and accessibility of healthcare have been conducted since the early 2000s. These two indicators are also used in measuring the overall satisfaction with the healthcare

![Figure 2: Assessment with the quality of healthcare % (EHIF, Annual Report 2012, 29)](image1)

![Figure 3: Assessment with the accessibility of the healthcare in % (EHIF, Annual Report 2012, 29)](image2)
reforms. Thus, variations in patients’ satisfaction can be logically connected with the healthcare reforms that were recently introduced.

Since the early 2000s, the EHIF and Estonian Ministry of Social affairs have conducted a survey called “Assessment of Health and Health Care by the Population”, measuring the perception of quality and accessibility of Estonian healthcare (EHIF, Annual Report 2012, 28). Figures 2 and 3 (from years 2007-2012) show that the accessibility of healthcare has received lower marks, but it is still generally regarded rather positive. Moreover, the strike of 2012 did not affect the perception of the accessibility of the healthcare, but on the contrary, showed signs of improvement.

However, the accessibility of healthcare is still a problem in Estonia. In particular, this does not refer to emergency care, but more to the long waiting lines at the medical specialists’ departments. This aspect of the health care system was also highlighted strongly in the strike in 2012. However, based on these two indicators, it can be stated that the respondents are satisfied with the Estonian healthcare and thus with the reforms.

In addition to the data of the research conducted by the EHIF and the Ministry of Social Affairs, Lai et al have provided a deeper analysis and have updated the survey with data from more recent years.

Figure 4: Satisfaction with the Estonian health care system, quality and access among population aged 15-74 from the time period of 2003-2012 (Lai 2013, 164).
Just like the previous figures show, figure 5 affirms that the quality of the service of the Estonian health care is highly assessed by the population. The main problem as in Figure 4 seen was the access to the health care, as 45% of the respondents considered this to be most negative aspect of the health care system (Lai 2013, 163).

![Graph showing satisfaction with healthcare services in Estonia](image)

Figure 5: Satisfaction with family physician, hospital and specialist services in Estonia among population aged 15-74 from the time period of 2003-2012 (Lai 2013, 164).

On the other hand, the satisfaction with the health services is relatively high. Thus, in 2012 for example, almost 95% of the respondents were satisfied with the hospital services. The same can be stated about family physicians and specialist services. Moreover, 85% of the respondents were satisfied with the digital prescriptions, which were one of the latest reforms introduced by the Estonian government.

Based on this data and the findings presented above, it can be stated that the Estonian people are satisfied with the quality of healthcare service. Although the main problem is access to healthcare, positive perceptions of it still prevail. Furthermore, the issue of access to healthcare, combined with low salaried and big workloads are aspects of healthcare that have been brought forth many times by medical professionals’ organizations and this has also been the main reason for the strikes.
Reforms in the Hospital Healthcare System of Hungary

The timeframe of the reforms in Hungary

Health care sector in Hungary presented very similar symptoms to that of peer nations in the former Soviet Union. In general, it faced high capacities with unsustainable needs of financing for the state budget. Main healthcare reform in the 90s could be defined as a problem of reconciliation of quality, efficiency, equity, universality and accessibility. Moreover, Hungary just like other European countries faces the challenge of aging population and the transformation of healthcare needs with the growing proportion of palliative care versus intervention for acute diseases. These trends pose an increasing financial pressure on national health systems (OECD 2010). The transition in Hungary in 1990 raised various expectations for different stakeholders in the health care sector. Healthcare employees expected normalization of their wages, patients looked forward for an increase in quality of services as a benefit of marketization, while the State was expected to continue assuming responsibility for efficient service provision (Orosz 2001).

The direction of health care reforms varied considerably throughout the last 14 years, without clear goals or benchmarks settled in terms of quantitative indicators to achieve in the long term. Each government change brought new overarching healthcare reform packages while neither of them was fully accomplished. Moreover, the health sector governance changed institutionally both in terms of level of governance – form central government to local and back- and in terms of sector of governance it was bundled to – from the Welfare Ministry to separate Ministry of Health and most recently to the Human Resources Ministry. Nevertheless, almost all health care reform programs converge in the following three main target areas:

- **provision of health services at appropriate care levels** – directing health care from hospitals towards outpatient care in order to reduce unnecessary use of high level\(^2\) services;
- **creation of efficiency through connecting the income of hospitals to needs of the population, quality and quantity of services provided** – general aim of limiting active hospital beds and increasing usage of the existing ones;
- **securing safe and continuous health services** for the population.

Although the main target areas have been constant, policy solutions and approaches varied throughout the years. Moreover, apart from these focus points, the problems of low wages, the existence of hidden payments and the problem of emigration of health professionals still remain.

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\(^2\) High level services stand for high level of complexity of services. The aim of sectorial reforms are to provide care at the lowest appropriate level of complexity. In partial terms this meant increased interaction with generalist and family doctors and reduced properly referred interaction with specialized hospital care.
In general, we can distinguish three major phases of healthcare reforms, which are shown in the following table:

**Table 1: Three generations of reforms in Hungarian Healthcare**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>First generation of reforms after the transition 1990-1998</th>
<th>Second generation of reforms 1999-2010</th>
<th>Recent reforms from 2010-ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Financing based on health insurance fund</td>
<td></td>
<td>- Increasing levels of corporatization and privatization</td>
<td>- Re-nationalization of ownership</td>
</tr>
<tr>
<td>- Decentralization of ownership and financing</td>
<td></td>
<td>- Re-centralization of financing though National Health Fund</td>
<td>- Operational framework: public budgetary institutions</td>
</tr>
<tr>
<td>- Limited introduction of P4P</td>
<td></td>
<td>- Introduction of pay for performance (P4P) mechanism and co-payments system</td>
<td></td>
</tr>
</tbody>
</table>

*First generation of reforms after the transition 1990-1998*

The beginning of the 90s was characterized by an insecure political environment where the government had multiple priorities to underwrite waste reform initiatives in practically all sectors at the same time. This brought high level of insecurity that affected the possible range of reform initiatives the government could underwrite without the risk of creating a wide dissent among the population. In the first part of the decade the main focus of healthcare reforms was to modernize its financing structure to achieve a more efficient and effective system. According the reform program of the Welfare Ministry (“Action Plan”), an internal market was created, operating though the combination of solidarity-based financing on one side, and a market-like incentive system in service provision in form of quality-for-pay systems on the other side. Decentralization of the sector was regarded as a desirable goal in order to adjust capacities to needs. In reality, the first years of the decade brought major changes solely in the financing side and not in the introduction of real market like incentives. This was mainly consequence of the reservation of the government to introduce too much variation in the healthcare system, which would in turn trigger possible opposition in the sector. Health insurance funds were created at self-governance level with the proclaimed aim of adjusting financing needs to local realities. Nevertheless, many times this autonomy of self-governments remained a only a formality, as the Ministry of Finance had a major influence on how the budget was allocated to the healthcare sector (Orosz 2001).

In the second part of the 90’s the main focus was set on the institutional structure of healthcare sector, and the reforms aimed to increase the autonomy of the management of hospitals through corporatization and the setup of municipal-level strategies, both in terms of financing and of capacities. Privatization of health services
was made possible with the Government Decree 105/1995 (XII), when separate subsections of hospitals were privatized. These sections become business entities selling their services to the ‘mother institution’. These services ranged from auxiliary operations as laundry, catering etc. to integral medical services as diagnostics, physiotherapy or even emergency over hour services. This form of privatization made integral management of hospitals difficult as leverage of the management has narrowed down to partial sections of hospitals’ operation. Moreover, labor relations became rather disorganized, as the very same personnel of public institutions in certain services were also employed as contractors. Often the most profitable services were outsourced to private companies leaving public hospitals in a difficult situation to balance their financial accounts.

Market-like incentives to control expenditures were never really introduced. Basically, the public insurance bought services from different hospitals at different institution-specific rates (Ororsz 2001). This mechanism inhibited all sorts of price competition in the sector. In 1996 a more administrative control of expenses was introduced. Municipality level health insurance funds were assigned an absolute number of services they were allowed to purchase from hospitals. This administrative control of hospital capacities could not ensure capacities to respond to real needs moreover and failed to improve efficiency and quality of service in hospitals.

A new Healthcare Law was enacted in 1997 that specified the professional legal and structural framework of the sector. For the first time, this law introduced legal basis of quality insurance schemes in the sector.

A conclusion can be drawn that the first phase of healthcare reforms were unable to offer a comprehensive solution for the surplus in capacities and inefficiencies, even though they reduced the number of active hospital beds. Meanwhile, financing of services and wages in healthcare were lagging behind the ones in other sectors, which finally resulted in creating tensions among employees.

![Health care provision capacity Hungary](image)

*Figure 6: Healthcare provision capacity in Hungary. Note: Lack of statistical information in years 2000-2001*
Second generation of reforms 1999-2010

In 1998, a new right-wing government assumed power. A separate Ministry of Health was charged to manage health care sector reforms. According to the government’s program (On the eve of the new millennium, 1998) health care financing was overly complicated and obscure at the level of local government health funds. Therefore, a central national level Health Fund was assigned to this role. Nevertheless, hospitals were maintained in local government property with increasing privatization levels. The government introduced a normative pay-for-performance system. The Health Fund bought services from hospitals at a normatively set price level independently from the input those services entailed. Also the family doctor system was fully privatized. General Practitioners system was designed to serve as a ‘guard’ before patients get to higher care levels in hospitals. The aim was to reduce the number of patients supplied in hospitals. Also a system of regional specialized care centers was assigned in order to bring simple treatments closer to patients’ residence. A general management supporting information system was introduced in order to increase efficiency with help of real time data on care provided in hospitals. First time the question of wages was mentioned in the government program. Nevertheless no significant steps were made in order to normalize wage levels in the sector.

In 2002 the socialist coalition came back to government. The program called “Decade of health care” was launched. It turned again towards regionalization of health governance with setting up Regional Health Committees responsible for regional level health care planning and reforms. Private capital in hospital care was involved in order to encourage the corporatization of hospitals and special care services. Moreover, the government opened the possibility for hospitals to sell their free capacities to private auxiliary insurance companies. In the framework of wage normalization of public employees, an average 50% wage raise was accomplished (Origo 2002). However, it is important to underline that the average raise affected employees in an uneven manner and due to the national tax regimes many times it didn’t translate into significant net salary raises (Ororsz 2001). Therefore, this measure could not solve structural problems of wage tensions and growing lack of health professionals due to migration.

The second part of the decade was characterized by a continuous attempt to limit the unnecessary usage of healthcare services and to raise awareness and clarity among patients, doctors and health funds about the monetary costs of services provided. Also, a stricter check of insurance coverage was introduced in order to filter abuses. This attempt materialized firstly in including a price tag at each treatment report. Secondly, in order to incentivize stakeholders to rationalize use of services in 2006 the government introduced visit fees and daily fees on each day spent in hospitals. This step raised hard opposition from the population and the case was heavily politicized. The initiative was finally vetoed on popular vote in 2008 March (OVB 2008).
Also, privatization efforts have winded down as main private investors withdrew from the sector, though corporatization has not stopped. Until 2010, 30.9% of publicly owned hospitals have changed their status to more independent corporate legal forms (ESKI 2010).

**Recent reforms (2010-ongoing)**

In 2010, the right wing coalition returned to government. The new government initiated overarching reforms within its ‘Semmelweis Plan’ that designated the State as primarily responsible to organize and manage healthcare services. However, it is difficult to assess the direction of this reform program, since some of its elements are rather contradictory between each other. Thus, while on one side this program encourages higher level of involvement of private actors, such as tax exemption of employers to provide private health insurance coverage to employees (azenpenzem.hu 2012), it also stipulated that all municipally-owned hospitals were nationalized and transferred to central state ownership. Moreover, even though the aim of the ownership change was in many cases explained as a bailout of indebted institutions, there were still many financially healthy centers were also taken from municipalities.

Nationalization of hospitals also brought management structure change. Hospitals started to operate as budgetary institutions, thus losing great part of their independence in management. For hospital employees nationalization of institutions meant a change of their labor status back to public employees. This development in turn was the reason for major tensions in the sector. Furthermore, at the level of service provision the program aims to define patient paths to introduce logical and effective levels of care hierarchy. For this purpose, the regional structure of care providers was redesigned by creating eight districts to replace the former county-based structure (Semmelweis Plan 2010). The plan also proposes to introduce a centrally-defined career plan for employees, including wage raises in order to respond to the rising problem of professionals’ emigration.

In sum, we can conclude that health sector reforms are characterized by back-and-forth steps in terms of corporatization and decentralization. While none of the reforms addressed and could solve long term problems of growing shortage of healthcare professionals, low wage levels, existence of parasolvency, inefficient use of capacities, growing waiting lists for interventions and general lack of financial investment in the sector.
Reactions of stakeholders

A. Employees

In the case of Hungary, the reaction of healthcare employees to various reforms in the sector has been largely influenced by fragmented representation and low level of unionization (Kahancová and Szabó 2012). Collective bargaining is mainly shaped by three associations: Democratic Union of healthcare Employees (EDDSZ), Hungarian Medical Chamber (MOK) and Hungarian Association of Residents. Changes over the past 14 years in the level of autonomy of hospitals and with that the status of healthcare employees (from public employment to private and back) did not have significant effect on wage levels. In both private and public employment wages are low in comparison to corporate wage levels.
Apart from collective bargaining, the main form of collective action were protests among healthcare employees: especially doctors and residents. The general reasons for these protest were labor conditions (over hours) and low wage levels (for detailed account of protest see Appendix 2). It is important to mention that given the relative high number of public servants in the health sector, reforms pertaining public servants in general (and not healthcare in particular) had an impact on employees in the sector of healthcare. The table below enumerates the reform initiatives that triggered reaction from employees or employees’ associations and unions in the health care sector. Overall, the main reason of organized protests were wage conditions, whereas labor conditions of young professionals and residents were also prominent topics for organized action. Since the Law on Strike for healthcare professionals prescribes certain level of service that has to be maintained, healthcare employees used only partial strikes, work deceleration and resignation campaigns to express their dissent. Protests tended to be sectorial or specific hospital-based efforts. This is most likely true due to the low culture of strikes in Hungary and the fact that interest groups are scattered in the sector. However, since recently there is a growing tendency of coordinated campaign across sectors and also internationally across the Visegrad 4 countries.

B. General public

The general public had a little reaction to most of the reforms apart from the 2008 public vote on co-payments. This might be due to a general apathy of the society but also due to the discrepancy between perceptions of healthcare among patients and doctors. Thus, there is a relatively large and growing difference in how much patients and doctors trust the healthcare system.
It is difficult to assess how far reaction of employees and the public had shaped policy reforms. This is mainly due to the fact that reform initiatives were variable throughout the years and even the same government had adjusted its own agenda on this sector rather abruptly. The two most considerable feedback loops were related to the introduction and its consecutive veto at popular vote of co-payments. Secondly, the recent resignation campaign by residents managed to force negotiations and lead to eventual rise of salaries of certain professionals. Again, given that these achievements do not affect the entire sector equally, it is not clear how far it will have further effects on overall service quality and satisfaction levels. We should also emphasize that given the surprisingly high levels of trust of the population in the healthcare system, it is unlikely that sector specific protests can scale up achieving cross cutting changes.

**Conclusion**

The direction of health care reforms varied considerably throughout the last 14 years, without clear goals or benchmarks settled in terms of quantitative indicators to achieve in the long term. Each government change brought new overarching healthcare reform packages while neither of them was fully accomplished. Health sector governance changed institutionally both in terms of level and area of governance under which reforms were undertaken.

The reactions of health sector employees were scattered across different interest groups. The most prominent focus of employees’ protests is the low level of wages in comparison to other sectors and also to the increasing level of pressure due to emigration of professionals in the sector. It is unclear how far protest efforts had an impact on the course of policies and consequently the quality of services. Nevertheless, employee representative associations lately tend to coordinate their actions in order to exert higher pressure on the government. The most recent resignation campaign of residents complemented with the overtime refusal campaign of doctors managed to negotiate better wage conditions. However, since service satisfaction among users is still high, it is unlikely that health professionals could benefit from coordinated protests.
Reforms in Hospital Healthcare System in Macedonia

Timeframe of the reforms (1991-2014)

Since the independence of Macedonia in 1991, the policy area of healthcare has been the target of more reforms than any other. The post-socialist political and economic context, the turbulent political stage in the country and the policy diffusion process under the influence of international organizations such as the International Monetary Fund and the World Bank (Center for Research and Policy Making 2007) have greatly affected the pace and the substance of healthcare reforms in the country. In a paper which provides an overview of the reforms implemented in Macedonian healthcare during the 20 years of the country’s independence, Lazarevik et al have identified three periods of different reformation policy trends: post-socialist (1991-1998), pro-market (1998-2006) and manifesto-driven (2006-2011) (V. Lazarevik, et al. 2012). This particular categorization has been based on the analysis of different policy documents in conjunction with the shifts in the decision-making powers of different political structures and is built upon the hypothesis that ‘the healthcare reforms are not continuous and are strongly associated with the political changes in the country’ (V. Lazarevik, et al. 2012, 177). Thus, since the country’s independence in 1991, almost every change of government has been accompanied by major reforms in the healthcare, with inconsistencies present even within a single term of government. This has ultimately contributed to the creation of the dubious picture of Macedonian healthcare reforms across just over two decades – marked with uncertainty, inconsistency and a very limited success.

The post-socialist (1991-1998) period was marked by the set of policies which were implemented in order to prevent the collapse of the national healthcare system, such as the restructuring of hospitals and the introduction of the co-payment system for healthcare services. Additionally, Macedonia officially opted for the model of a welfare state and included the right to social security and social insurance and the right to health protection in the 1991 Constitution. However, this period was also marked by a considerable decrease in revenue of hospitals by 40% (V. Lazarevik, et al. 2012, 178) and an increase in debt, both of hospitals and at the central level. However, structural reforms lending from the World Bank as well as humanitarian aid from international actors were used in order to maintain the minimum level of stability of the healthcare system.

The pro-market (1998-2006) period was marked by a chain of reforms that were implemented within the framework of the World Bank’s Health Sector Transition Project and brought reforms that strengthened the independence of the state Health Insurance Fund and privatized certain parts of the healthcare system in Macedonia. In order to address the problem of efficiency and accountability in the financing of healthcare services, in 2000 a new Health Insurance Law was adopted and the Health Insurance Fund was formally separated from the Ministry of Health and established as a semi-autonomous entity. Following the armed
conflict of 2001 and the adoption of the new Law on Local Self-Governance in 2002, basic healthcare was decentralized to local municipalities. This law brought extensive competences to the local government: management of public healthcare organizations and entities in primary healthcare; health education; adoption of policies to promote health; prevention activities; protection of workers’ health; health management of the environment and other (Law on Local Self-Governance 2002). In addition to the process of decentralization, another major reform was the privatization of primary healthcare clinics, dental clinics and pharmacies. By 2007, a total of 3,521 health workers, such as dentists, pharmacists and nurses were privatized (V. Lazarevik, et al. 2012, 179). However, the privatization of the bureaucracy serving in hospitals throughout the country was postponed during this period and it was never actually fully implemented after the change of government in 2006. Considering the oversized population of the state-employed bureaucracy in hospitals, privatization of this section of the healthcare system would be a ‘politically unpopular reform’ (V. Lazarevik 2010, 50) and there are no prospects that this privatization would be implemented anytime soon.

The change of government in 2006 marked the beginning of the manifesto period, which brought probably the most extensive reforms in the healthcare system since the country’s independence in 1991. Reforms in this period were focused on promoting efficiency and accountability of healthcare providers, as well as improving the infrastructure of the healthcare system through the purchase of medical equipment and the renovation and building of new hospital buildings. In the period of 2006-2011, probably the biggest reform was the introduction of new form of management of public healthcare providers, whereby a dual system of directors was introduced, one out of which is a medical doctor and the other an economist (Law for Changes and Amendments of the Law on Health Protection 2007). Even though this reform was intended to promote efficiency and independence of public healthcare providers, in practice these directors have lacked autonomy and their appointment has been heavily influenced by political structures in power (V. Lazarevik, et al. 2012, 181). Other reforms implemented in this period were no different in that regard, as the process of drafting and implementation was largely politically motivated and brought disunion among healthcare workers, depending on their political affiliation.


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Despite the fact that the reforms throughout the past 20 years have been frequent and extensive, none of these reforms have targeted one of the most acute problems of Macedonian healthcare, which is the sizeable body of bureaucrats employed in the healthcare sector. This problem has aggravated even more since the global economic crisis, when the population sought for a ‘stable employment’ in the public sector. Lazarevik has located the root of this problem in the legacy from the communist party’s interest to provide ‘full employment’ along with the inefficiency of the public enterprises, as well as the corrupted and non-transparent hiring in the sector which so far has been under the direct influence of the ruling political party and based solely on partisan membership rather than merit and competence (V. Lazarevik 2012, 40,41). In this article, he goes as far as stating that ‘the condition of the healthcare sector and the influence of politics nowadays is very much alike the one of socialist enterprises in the end of the 1980’s and the beginning of the 1990’s’, while the competence and managing skills of current directors of hospitals ‘starts and begins with the instructions issued by the party’s headquarters’. Currently, some 75-90% of the annual budgets of public healthcare providers is dedicated to wages, clearly indicating the huge burden of bureaucracy, while concurrently facing a lack of medical personnel (ibid). Finally, Lazarevik suggests two possible solutions for these structural challenges of the healthcare system of Macedonia: either corporatization and networking of the hospitals, or a complete privatization of healthcare, under a close regulation by the state.
In the following sections, this paper will reflect on the most important reforms implemented during the period of 2011-2014, since this period has had the greatest impact on creating the current condition of the healthcare system in Macedonia. The adoption of the new Law on Health Protection in 2012 has laid the foundation for a wide array of policies which were introduced starting 2012 and are still in place. Additionally, since 2006 the same political party has been in power in Macedonia, whereas the current Minister of Health has held office since 2011.

Overview of the reforms implemented in the 2011-2014 period

The last decade and the period between 2011 and 2014 in particular, have been marked by a dynamic pace of change and reform in Macedonian healthcare. This period of intensified reforms has brought multiple issues of coordination and management of implementation of these reforms, bringing plenty of confusion to both patients and medical personnel about which system is currently in place and what is the proper method to implement the newly enacted reforms. The amount of stress for patients and medical professionals has increased considerably, ‘not only because the ways to access services have been changed, but also due to the increased administrative procedures and patients’ clueless roaming through different hospital departments, pharmacies and offices in order to correct mistakes [made by the uncoordinated implementation of various reforms]’ (Boskovska-Zlatkova 2012). In the following section, this paper reflects on the most influential reforms, assessed in terms of their effects on the quality of healthcare services and the reactions on the side of medical professionals and patients.

A. Pay-for-performance (reporting) (P4P) model

Following the global trends in the past decade and the notion that financial incentives can positively affect efficiency and quality in medical services provision (Schwab and Olson 1990) in July, 2012 the Ministry of Health introduced a new system of wage calculation for doctors, which is based on the number of medical interventions reported within a month. Comparatively, there are numerous pay-for-performance (P4P) models, but two important notions make the main distinction between them: what constitutes ‘performance’ and how it is measured. Thus, four basic models are distinguished:

- Pay for quality;
- Pay for reporting (P4R);
- Pay for efficiency;
- Pay for value (Trisolini, et al. 2011).

The system which was introduced in Macedonia fits within the pay-for-reporting (P4R) model, designed after the Performance-Based Supplementary System implemented in the public healthcare providers in Turkey. At the core of the Macedonian model lays the system of mandatory reporting of each medical intervention by each individual physician. However, an important distinction from the Turkish model is the fact that the one
implemented in Macedonia is based solely on quantitative indicators for the individual performance of the doctors. Thus, the physicians’ basic salary at the time of introduction of the reform is taken as a starting point, while variations in workload reported may be reflected through a change in wage of +/-20% of the basic salary. Finally, the performance of a single physician is compared with the performance of his colleagues within the department (Lazarevik and Kasapinov 2013).

The enthusiasm of the P4R in Macedonia has been extensively challenged by experts in the area, since there is no evidence confirming that these reforms have been particularly successful in Macedonia so far. Moreover, no clearly successful model has been identified in other countries as well, as controlled trials of P4P have been rare and relatively small in scale (Mullen, Frank and Rosenthal 2010). Thus, Lazarevik et al report of a comparative study in 252 hospitals in the USA that found no evidence that the P4P is more successful. A 2010 study that compared the performance reports of medical organizations under a P4P scheme contracting with the PacifiCare Health Systems in California with the ones of hospitals contracting with Pacific Northwest (where no P4P scheme was implemented) have shown that the P4P had a positive impact on ‘some of the clinical measures rewarded by the programs’, and that positive impact relied on the expected reward (ibid, 66). However, the study found no evidence that the program brought a ‘major improvement of quality or notable disruption in care’, and that the effects of financial incentives in programmes as the P4P does not have ‘the dramatic or even predictable effects’ promoted by its supporters (ibid, 66).

Unlike the model which was implemented in Macedonia, relevant literature states that ‘a typical P4P program rewards healthcare providers (e.g., physician medical groups) with bonuses or high marks on one or more quality measures, such as rates of preventative screenings or adherence to guidelines for chronic disease management’ (Mullen, Frank and Rosenthal 2010, 65). The Macedonian model differs from this definition on multiple grounds, as the P4R system has been set both to reward and punish variations in number of medical interventions reported, only individual work is considered and quantitative indicators (such as number of medical interventions) are considered. An example of a set of more suitable indicators which can measured in the P4P system would be the one of the Quality and Outcomes Framework (QOF), which was implemented in the UK. Unlike payment based on the number of medical interventions reported by individual physicians, this system featured performance indicators such as successful period review and control of conditions such as high blood pressure and diabetes. Furthermore, good results in these indicators were rewarded according to a scheme of monetary rewards, which were awarded to each general practice in order to promote ‘collective behavior’, unlike the model adopted in Macedonia (Maynard 2012, 6). Additionally, rather than measuring the individual physician’s performance, examples of P4P systems where indicators focused on patients (for example measuring obesity) (Cawley and Price 2011) or the performance of a clinical team (Maynard 2012, 7) have been deemed more successful.
According to experts in the field, there is no additional budgetary means provided for this project and that hospitals function on the same budget as they did before the introduction of the P4P reform (Atanasova-Toci 2013). In order to be rewarded a bonus, doctors need to perform more surgeries within the same budgetary constraints as before, while those who report less interventions within the department practically give away their salary to their colleagues. Thus, even if there was a functioning incentive for doctors to perform better under the P4P system, the current budgets would not allow the system of bonuses to be implemented in practice: bonuses can only be transferred from one doctor’s to another one’s pocket, but not all of them can be awarded at the same time. This has turned out to be detrimental to the team work and intra-department relations between physicians, inducing many to dub the system as ‘unfair, ‘ill-advised’ or even ‘gladiator-like’ (ibid).

A survey conducted by Healthgrouper (an online provider of comprehensive information for doctors and health services providers in Macedonia) on a sample of approximately 300 respondents among physicians in the public and private healthcare reveals a few of the major weaknesses of the P4R system implemented in Macedonia. Responding to an open-ended question, medical doctors specified three major groups of problems with the payment system: the current P4P model does not measure quality of the services provided; it lacks transparency and it creates conflicts within clinical teams and departments (Lazarevik and Kasapinov 2012, 441).

The lack of indicators of quality in the current P4R system raises concerns that physicians would be motivated to only focus on quantity, on the account of the deterioration of quality of services. This argument is supported by the finding that providers regularly shift their resources mostly toward ‘rewarded dimensions’, which often results in a drop of the overall quality of services (Mullen, Frank and Rosenthal 2010, 65). Also, there has been criticism that this reform was ill-advised and focused on ‘increasing or decreasing the wages of medical professionals’ rather than maximization of the patients’ satisfaction (Atanasova-Toci 2013, 194) or the maximization of the general population’s health (V. Lazarevik, D. Donev, et al. 2010, 876), which should normally be pursued as goals in public health policy-making.

Another criticism which has been addressed to the P4R scheme introduced in Macedonia was the fact that it introduced further administrative measures for doctors and increased their total workload (V. Lazarevik 2012). A survey by the Healthgrouper Research Center administered at the time of the introduction of the P4R reform has confirmed these concerns. Thus, from a population of 135 physicians from across the country, some 56% reported that on average it takes them more than 40% of their time with patients to complete the administrative procedures, while almost 30% of the respondents reported they spend more than 30% of their time completing those tasks (ibid, 195). This undoubtedly has a negative effect on the quality of services and the relationship between physicians and patients, since the former have less and less time to devote to their patients, as their workload is increased by the burdensome administrative procedures and paperwork.
In conclusion, the pay-for-reporting reform has had a major influence in shaping the current healthcare system in Macedonia, since it introduced a completely new system of wages for medical professionals and affected their workload and the quality of services. However, the process of enactment and implementation of the policy has been marked by lack of transparency and lack of evidence-based policy making. The final impression of this reform is that it has been a fine example of priority-setting in healthcare policy where ‘political self-interest’ has dominated over cautious policy-making (V. Lazarevik, D. Donev, et al. 2010).

B. E-governance in the healthcare system

Starting 2009, the Ministry of Health has embarked on a reform to digitalize the work of the state Health Insurance Fund and to enable online appointments for medical examinations on every level of healthcare.

The first segment of electronic governance in healthcare is the Electronic Insurance Card, which is provided to everyone covered with the universal health insurance of the state Health Insurance Fund. The card replaces the system of paper blue cards, which was used to prove the status of an insured person before the healthcare providers. These electronic insurance cards are used for identification and authentication of all users, a controlled access to personal data of the insured and the easy provision of healthcare services covered by the insurance plan (Ministry of Health of the Republic of Macedonia 2009).

The second segment of electronic governance which was implemented after the introduction of the Electronic Insurance Card is the online platform ‘My Appointment’ (‘Мој Термин’) which enables users to make appointments for medical examinations online, whereas physicians can prescribe medications and re-direct patients electronically. However, the media reported that this project had begun before the project to cease hard-copy bookkeeping and before the necessary software was delivered to medical organizations, thus creating confusion and unnecessary workload among both health personnel and patients (Boskovska-Zlatkova 2012).

C. Infrastructural investments

In 2011, the central government has been engaged in a project to renovate the premises of a total of 41 institutions in healthcare, whereas the building proceedings for a new central complex of clinics has been initiated in 2012 (Ministry of Health of the Republic of Macedonia 2013). The reconstruction project is estimated at around EUR 100 million, making it the biggest capital investment in healthcare sector since the country’s independence, according to the Ministry of Health. However, even though this reconstruction project was scheduled to be finished by the end of 2014, its feasibility is an issue since not more than half of these reconstructions projects have been finished or are still pending (Makfax 2014).
Reactions of Stakeholders

**A. Medical professionals’ reactions to reforms and job satisfaction**

A survey which was conducted by the Healthgrouper Research Center before the introduction of the pay-for-reporting scheme reveals a great amount of dissatisfaction among physicians working in the public sector of healthcare in Macedonia. The low salary, physicians’ treatment on the side of the state and the amount of stress and dissatisfaction with healthcare reforms have been qualified as the key factors contributing towards the high level of dissatisfaction within the medical profession (Healthgrouper 2012). The report especially highlights recent healthcare reforms as a generator of dissatisfaction, as 77% of physicians working in state-owned hospitals and 72% of physicians working in privately owned hospitals expressed dissent with the reforms.

The introduction of P4P is accredited to have negatively affected the status of medical personnel in state-owned hospitals in Macedonia. The introduction of this reform brought unity among the majority of doctors to the extent that was not noted before, as they expressed their dissatisfaction by organizing the first general strike of doctors since the country’s independence in 1991 (Lazarevik and Kasapinov 2013). However, this protest was not welcomed on the side of the government, as immediately after the announcements of a general strike, the Minister of Health raised judicial proceedings against its organizers. After an unusually swift procedure, the judiciary stood on the side of the Ministry, banning the doctors’ strike under the explanation that the organizers did not adhere to the rules of procedure and did not provide proper organization of work during the strike (Boskovska-Zlatkovska 2012). On the other hand, the strikes of the representative union were paralleled with the establishment of other unions that expressed support for the P4R, thus spurring speculations that these new unions were ‘politically initiated’ (Lazarevik and Kasapinov 2012, 441). These developments finally resulted in splitting the unity within the medical profession and prevented the success of the opposition against the introduction of the pay-for-reporting system in Macedonian healthcare. Moreover, the Minister of Health refused to negotiate with the Independent Union of Clinical Centers (the principle organizer of the physicians’ strike) because ‘their strike has a political background’ (Vest 2012), alluding to connections of the union leaders with the opposition party. He also said that the strikers’ efforts would be futile, since ‘they would still go back to work and still fill in information on the P4R system’ after the strike and that the organizers of the ‘illegitimate strike’ will bear consequences (Vest 2012). The latest event linked to the strikes against the introduction of P4R is the apprehension of Dr. Dejan Stavrik, who was leading figure in organizing the 2012 strikes (Jordanovska 2014). In an equally swift judicial procedure as the one that considered the legality of the strikes of 2012, he was sentenced to one year in prison for bribery (Vidimliski 2014).

A survey conducted by Healthgrouper amidst the 2012 strike showed great dissatisfaction with the P4P on the side of 312 physicians coming from 45 different departments. The particular survey showed a strong support
against the P4R reform among 65% of the respondents. Moreover, some 75.9% of the doctors strongly supported the strike organized by the Independent Union of the Clinical Center against the P4R reform. Another survey which was conducted amidst the strike against the P4R policy, showed that 91% out of 312 physicians surveyed, support the strike against P4R project because of the need for a ‘more dignifying treatment of medical professionals on the side of the authorities’ (Healthgrouper 2012). Almost one third of the respondents fully agree to being paid accordingly to their workload, whereas 42.5% agree to the same statement, finally showing almost 70% of support for a system of pay that would be in accordance with the workload of physicians. Thus, these results show that physicians are not particularly opposed to a system that would sanction or reward them according to their input of labor, but oppose the particular policy because of the lack of transparency in the policy-making process and the fact that it does not properly value varying complexity of medical interventions at different departments, as well aspects of teamwork and the individual profile of physicians.

In addition to the general strike, medical professionals expressed their discontent with the reform through the media:

“This model stimulates doctors to work too much. They work poorly because they are in a rush to perform as many check-ups as possible. In the process, patients suffer, while this costs the Health Insurance Fund much more” – Dr. Milco Panovski, abdominal surgeon.

“In order to avoid conflicts within the department, we all report the same number of medical interventions. However, you cannot value the quality and the work of a medical specialist without distorting the feeling of justice” – a surgeon employed in a public hospital.

“A certain surgeon may perform 5 surgeries on appendicitis without any complications, while another one may spend up to 5 hours in the surgery room working on a complicated surgery. The second one might have saved the patient’s life [by performing a difficult surgery], but he would still be awarded less points and will receive a lower salary than his colleague” – an economist director of a public hospital.

“All the anomalies we pointed out since the very beginning, have come out on the surface. The model itself has failed to achieve the goal of differentiating among well-performing and poorly-performing doctors. Quantity, and not the doctors’ professionalism have come out on the surface” – Dr. Dejan Stavrik, ophthalmologist. (Statements taken from Atanasova-Toci, “Saving human lifes is measured through points [orig. Спасувањето на човечки животи се мери со бодови], 2013)

In addition to the shortcomings of the reform itself, experts have identified ‘serious weaknesses in each part of the policy-making cycle’. Moreover, they have pointed to a possibility for multiple negative policy implications such as massive migration of physicians from the public healthcare to privately-owned hospitals, as well as the migration of health professionals abroad (Lazarevik and Kasapinov 2013, 31). To confirm the
probability of these potential negative implications, a survey from February 2012 with a population of 216 
physicians showed that a huge number of physicians consider to change their workplace: 31% of the 
respondents would transfer to a privately-owned hospital; 57% would move to practice abroad, whereas some 
11.6% consider changing their profession (Healthgrouper 2012, 22).

B. Reactions of patients

A survey conducted by the Healthgrouper Research Center in 2012 has found that the treatment of the 
patients by hospital nursing and administrative staff is the main source of patients’ dissatisfaction with 
healthcare services in Macedonia. The survey included a total of 531 respondents who responded online to 
an open-ended question “What would you like to be changed or improved in healthcare in the Republic of 
Macedonia?”. Other remarks have noted service waiting time and hygiene in hospitals as the most severe 
problems of healthcare. However, the P4P reform has also affected patients’ satisfaction with medical service provision. Thus, medical 
professionals confess that in order to be able to report more medical interventions they make unnecessary 
appointments and conduct examinations even in cases where diagnosis had been given (Atanasova-Toci 2013). 
Within the first year after the P4P reform was introduced, the media reported that some 70-80% of physicians 
in one of the public hospitals in Skopje were deliberately reporting false medical interventions in order to 
receive a higher salary (Naumovska 2013).

Finally, the increased burden of administrative procedures has deteriorated patients’ satisfaction with medical 
services, primarily because doctors can spend less time with patients (Healthgrouper 2012, 9).
Comparative Overview of the Healthcare Reforms in Estonia, Hungary and Macedonia

This section of the study provides a comparative overview of the main policy reforms undertaken in each of the countries considered previously. In that sense, the comparative overview will highlight the main common characteristics and differences in the path taken in each of the three cases. The final aim of the comparative overview is to bring light on the causes of the differences, while assessing possible learning points on success and failure of reforms. In order to have a complete understanding on reform initiatives this section will also reflect on the reactions of stakeholders to these reforms and how these reactions influenced the course of the reforms and the impact on service quality.

At first sight, Estonia, Hungary and Macedonia have followed relatively different paths in reforming their healthcare sector in over two decades of transition. However, similarities are present and these can be summarized through the following clusters of reforms: funding of healthcare services; management of hospitals and wages and employee relations. Naturally, there are differences and nuances in the how these policies were implemented in practice and the effects they produced within each national context. On top of this three clusters of reforms implemented in all three cases, we managed to identify similar problems which are present in various extent in all of the three countries. These issues are present in the three cases listed above and can be summarized in the following three categories:

- low wages of both doctors and other professional personnel;
- existence of hidden payments (parasolvency) (pertinent for Macedonia and Hungary);
- increasing emigration of health professionals.

These negative policy externalities can be attributed to a wide array of developments in the healthcare sector policy-making. In the case of Estonia, the wage negotiations which started in the mid-90s lasted for too long before a minimum-wage agreement was reached in 2002 and major tensions were present in the wage bargaining process in the following decade, which finally resulted in the general strike of 2012. In the Hungarian case, none of the policies implemented in the sector of healthcare actually addressed the issue of low level of wages and it was precisely this problem that has caused low level of job satisfaction among health professionals. Hungarian medical professionals expressed their dissatisfaction through the form of open letters, work slow-down campaigns, collective resignation letters and smaller protests, but the issue of fragmented representation and low level of unionization in Hungary prevented massive general protests. Finally, in the case of Macedonia, it was directly the introduction of the pay-for-reporting (P4R) reform that brought great dissatisfaction among medical doctors. Both practice and surveys conducted among medical doctors showed that this reform was detrimental for the quality of services, teamwork and relations among colleagues and that it effectively cut down doctors’ wages and had a major negative influence on the dignity
of medical professionals. This tremendous dissent was finally channelized through the first general strike of doctors since the independence of Macedonia.

However, these negative developments (which are especially visible in the cases of Macedonia and Hungary) can be summarized in the unsuccessful wage negotiations and flaws in the policy cycle that affects wages. In fact, low wages of medical professionals and the reforms that affected them have been the most common motivation for strikes and other forms of protests in all of the three countries.

Comparison of the reforms in the health sector

In the beginning of the 1990s Estonia, Macedonia and Hungary faced the challenge of reforming their highly centralized, inefficient and fully state-funded sectors of healthcare into sustainable, modern healthcare systems that could provide high-quality healthcare services to the population. As it was mentioned before, most of the reforms implemented in these three national context converged in the three clusters of funding of healthcare services; management of hospitals and wages and employee relations. The following paragraphs will provide a comparative overview of each of these three groups of reforms.

In the case of all these three countries, healthcare has been provided based on the system of universal coverage and this character has been maintained throughout the period of reforms and up to date. Additionally, series of reforms implemented in all of the three countries aimed to establish national health insurance funds as independent bodies responsible for managing the financial aspects of provision of healthcare services. In the all three cases, this reform came in the pro-market reformation period of the early 2000s, by either a formal separation of the health insurance fund from the relevant ministry (as in the case of Macedonia) or by establishing a completely new institution (as in the cases of Estonia and Hungary). Furthermore, in all of the three countries this body was granted the principal authority to contract providers and pay sickness benefit to the insured employees. In the case of Macedonia, however, a decision by the Constitutional Court of Macedonia in 2010 effectively deprived the Health Insurance Fund of the possibility to choose the providers which it would contract by ruling in favor of the possibility for reimbursement of costs for all health services regardless of the ownership of the providers.

Another issue that was extensively addressed with the reforms in all of the three cases has been the management and ownership of hospitals. In the case of Estonia this was practically introduced through the reformation of healthcare employees’ status from public servants to private labor employees and established the institution of family doctors. Additionally, through restructuring of hospitals in order to improve efficiency and induce sustainability of the healthcare, the number of hospital beds and the average stay in hospitals was significantly reduced. Finally, family doctors (or general practitioners) were privatized and subsequently contracted by the national insurance fund, similarly as in the cases of both Hungary and Macedonia.

The reforms of hospital management and ownership have shown to be relatively complex in the cases of Hungary and Macedonia. The peculiarity of these reforms is connected with the dynamics of the political cycle
in both of the countries, and very commonly the introduction and the implementation of these reforms has been linked with changes of government. In the case of Hungary the influence of politics and changes of government have been materialized through the fact that privatization and decentralization which were introduced in the 1990s were overturned by re-centralization of financing and re-nationalization of ownership in the subsequent changes of government. In the case of Macedonia, the process of privatization occurred in the pro-market period of reforms, when dentistry, pharmacies and primary healthcare clinics were privatized and the financing of their services was covered by the Health Insurance Fund. The process of decentralization followed the adoption of a new Law on Local Self-Governance in 2002, when many competences in the management of public healthcare organizations was put under the competence of municipalities. However, the historical allocations of budgets to municipalities and the political influences in the process have negatively affected the success of this reform. Finally, the reforms of hospital management in Macedonia introduced the dual system of directors for public hospitals, whereby a medical doctor and an economist were appointed to manage individual clinics. Unfortunately, the process of both appointment and the work of these directors have been heavily influenced by politics.

The policy cluster of wages and employee relations has been marked by long wage negotiations and relatively successful protests against low wages on the side of medical professionals. Throughout the last decade, through negotiations, Estonian medical professionals have managed to achieve a double increase of the minimum wage for nurses and technical staff, an increase of salaries of healthcare employees in 2005 and finally, another increase of the salaries of caregivers, nurses and doctors after the general strike of 2012. In Hungary, it took long before the government started dealing with the issue of wages, and it was not before the end of the 90s when the question of wages was mentioned in the government’s program. However, an average 50% wage increase came only after the change of government in the mid-2000s. Still, this reform was hampered by the fact that it affected employees unevenly and due to Hungary’s tax regime, the raise practically did not happen. Hungarian medical professionals expressed their dissatisfaction through various forms of dissent and the low level of wages has been the most common motivation for all kinds of protest. Finally, no policy projects significantly affected the wages and employee relation of Macedonian medical professionals before the introduction of the pay-for-reporting scheme. This policy reform effectively linked the salary of medical doctors with the number of medical interventions they would report within a month. However, the lack of controls for quality, indicators for teamwork and the complexity of interventions, as well as many shortcomings in the policy process itself, have had negative influence on the quality of the reform. Moreover, it can be argued that the P4R scheme did not change or even effectively cut down the wages of medical doctors, since the reform did not featured sufficient budgetary means for the programme, and doctors were put in a position to have to perform more interventions, but within the same budgetary constraints as before the P4R reform.
Reactions of stakeholders

Reaction of Health Care employees in the broader context of health care reforms

As highlighted in the previous sections, healthcare reforms in Estonia, Hungary and Macedonia were focused in the first stance on restructuring the financial framework of healthcare provision in form of establishment of independent health funds. In a later stage reforms were centered on restructuring hospital care provision management in form of decentralization and introduction of some level of corporatization of the establishments. Even though Hungary and Macedonia presented hectic course of policy reforms while Estonia practiced a more balanced and long-term policy reform cycle, the three countries coincide in that reforms and policy process as a whole were originated from the political sphere –in form of electoral programs or specific ministry-level, closed, policy programming- marginally involving wide stake holder input or consultation. This way reforms could not take into consideration the opinions of employees, nor aimed at acting on human resource development in health care. In each case reform programs stemmed from particular political agendas not involving broad sectorial consultations –this is particularly valid for Macedonia and Hungary where reforms initiated from specific government or electoral programs.

Labor unionization was relatively fragmented in all of the three countries, thus preventing labor unions and other employee’s associations from playing a significant role in the policy formulation process. The combination of the two phenomena –low level of openness to input from employees on the side of policy-makers and low capacities for providing input from the labor unions- have led to the fact reforms failed to tackle structural problems of wage consolidation. In the longer run, the widening difference of wage levels between national health care employees and foreign peers as well as between the health sector and other private sector wage levels has led to high level of emigration of health care specialists in each of the countries. The dimensions of such emigration put even higher pressure on employees who had stayed in form of increased workload triggering further discontent with wages, working conditions and the emergence of hidden payments –particularly present in Hungary and Macedonia.

In recent years, each of the countries faced with strikes of health care employees. Though the trigger of the strikes was different in each case, it is clear that the main goals of recent protests were wage increases and normalization of work load (over-hours). In Estonia, health labor unions went on general strike to put pressure on the State in order to conclude collective wage negotiations. The strike lasted 25 days and concluded with success for the employees in form of a collective agreement that guarantees full salaries for residents a reduction of the workload of doctors and nurses by 20% the ambulant and 14% in their stationary work (Delfi (4) 2012). Additionally, the minimum salaries of caregivers, nurses and doctors were raised by 23%, 17,5% and 11%, respectively (ibid). In Hungary the most important recent protest movement was initiated by residents in form of a resignation campaign. The campaign was supported by the Hungarian Association of Doctors. The protests were not reacting to particular reform –as it was the case in Estonia- but aimed to pressure the
government to act in face of a systematic lack of wage reforms and to commit itself to new collective wage settlement. Though previously there were scattered strike initiatives in the Hungarian health sector, those mainly materialized in processing only emergency cases or similar action of work slow-down. Furthermore, the resignation campaign was a unique form of protest. This campaign also brought unprecedented solidarity in the sector. In face of the campaign and the support protests, the government committed itself for inclusive negotiations on a long-term policy on employment conditions, wages and human resource development for the sector, but the results of this commitment are still unclear. In Macedonia protests started as a direct reaction to the introduction of a P4R system in public hospitals that proposed to link doctor’s salaries directly to the number of interventions, without consideration for qualitative concerns. The system was both ethically unacceptable for doctors and also supposed increasing burden of employees for their wage. The reform initiative was highly unpopular among professionals and finally led doctors to a general strike in 2012 – the first since the independence of Macedonia. According to sectorial surveys, 75% of doctors supported the strike. Nevertheless protests were declared illegal and the leader of the strikes was arrested. It is still unclear how the sector will bear with the new system in the long term. According to opinion surveys of professionals, many consider leaving the public health sector or the country (86% in total, according to Healthgouper).

In view of the three recent protest actions in Estonia Hungary and Macedonia it is interesting to point out that in spite of the corporatization and privatization of hospitals, general strikes were the more effective in raising awareness on the wage and work conditions of health care employees, while small-scale localized initiatives had only marginal success. In general, the results of these protests were highly dependent on the overall state of democratic institutions and the responsiveness of the government. Both Estonia and Hungary witnessed drastic forms of strikes - 25 days lasting strike and resignation campaigns - that concluded with an agreement (though in the Hungarian case the long term effects are unclear), while in the Macedonian case the strike was immediately shut down with questionable repercussions for the participant union leaders. The actual outcome of the protests points further than the effects of NPM reforms and industrial relations within the sector and brings our attention to much broader questions of inclusiveness of the policy process and the guarantees of rights for employees.

Public satisfaction with the reforms

In order to assess public satisfaction with the reforms and the reaction of service users to protest of employees in the sector, this study relied on surveys on user satisfaction that were available online. In all of the three countries public satisfaction with the health care services is systematically higher than those of healthcare employees. In Estonia, satisfaction with the health care system services has been constantly higher than 85% since 2002 (See Haljasmets part, Figure 4). In this sense, the Estonian healthcare service is assessed rather highly among its consumers, while accessibility of the health services is the most worrying aspect of the sector (See Haljasmets part, Figure 3). The main complaint that the patients have is that the queues for the medical specialists are too long. Similarly, in the Hungarian case, the patients have high level of trust in the healthcare,
as it scaled up to 90% in the third quarter of 2013. In Macedonia, the main concerns of the public with health care are the treatment of the patients by hospital nursing and administrative staff, as well as the issue of hygiene. The introduction of the P4P system also had direct impact of patients’ satisfaction as it made the healthcare administration heavier leaving less capacity for actual treatment and care.

In neither of the countries we could trace a direct reaction or any kind of mobilization in support or in opposition to reform initiatives and strikes of medical professionals. The only exception to this tendency was the Hungarian referendum on co-payments for public health services (visit fees) in 2008. However, since the referendum covered a wider range of reforms in public service and was highly politicized, it is hard to draw conclusions related particularly to the sector of healthcare. Explanation for such abstention from direct reaction of the public might be due to the low level of social solidarity and cohesion and the lack of tradition of direct democracy in the three countries.
# Appendixes:

Appendix 1, Estonia: Main powers and authority in the system of healthcare (Jesse. 2008: 6-7).

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

<table>
<thead>
<tr>
<th>Estonian Family Doctors Association</th>
<th>Paying sickness benefits to insured people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional development as well as representation of interests in developing reimbursement, contracting policy and legislative process</td>
<td></td>
</tr>
<tr>
<td>Advisory</td>
<td></td>
</tr>
<tr>
<td>To members</td>
<td></td>
</tr>
<tr>
<td>Change of management</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Paying sickness benefits to insured people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financially sustainable provision of high-quality health services</td>
<td></td>
</tr>
<tr>
<td>To founding organizations (local governments, Ministry of Social Affairs and universities)</td>
<td></td>
</tr>
<tr>
<td>For Management Board – loss of job</td>
<td></td>
</tr>
<tr>
<td>In some cases loss of performance-related pay</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Union</th>
<th>Paying sickness benefits to insured people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation of corporate interests in reimbursement policies</td>
<td></td>
</tr>
<tr>
<td>Contracting policy and health care legislative process</td>
<td></td>
</tr>
<tr>
<td>Management training courses</td>
<td></td>
</tr>
<tr>
<td>Advisory</td>
<td></td>
</tr>
<tr>
<td>To members</td>
<td></td>
</tr>
<tr>
<td>Change of management</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consumers</th>
<th>Paying sickness benefits to insured people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation of consumer interests</td>
<td></td>
</tr>
<tr>
<td>Advisory</td>
<td></td>
</tr>
<tr>
<td>To members of the respective organization</td>
<td></td>
</tr>
<tr>
<td>Withdrawal of representative from working groups etc.</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 2, Hungary: Reaction of public employees to health care and public service reforms from 2006

<table>
<thead>
<tr>
<th>Date</th>
<th>Reform initiative</th>
<th>Topic</th>
<th>Reacting organizations</th>
<th>Reaction type</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>After the transition employees decided to work as third party consultants or contractors because of the flexibility and lower tax burden of this kind of employment. The state in aim to avoid fake contracts covering full time employment status obliged contractors to move to formal employment. (Labor law paragraph 75).</td>
<td>Privatization</td>
<td>Hungarian Chamber of Doctors Council of Public Servants, Trade union Commission</td>
<td>No coordinated effort, in some institutions doctors were not signing their new public servant contracts</td>
</tr>
<tr>
<td>2007</td>
<td>Change of financing structure of the resident program in order to channel new doctors towards those specialties where there is a shortage of professionals.</td>
<td>Training</td>
<td>Hungarian Association of Residents</td>
<td>Open letter to the Health Minister to ask him to revise the planned structure change and to engage in negotiations regarding the new system</td>
</tr>
<tr>
<td>2007</td>
<td>Privatization of the Public Health Fund</td>
<td>Privatization</td>
<td>Across public servants</td>
<td>All sectors of public servants entered the strike</td>
</tr>
<tr>
<td>2007</td>
<td>0% wage increase</td>
<td>Wage</td>
<td>Various public employee unions</td>
<td>Work slow-down campaigns</td>
</tr>
<tr>
<td>2008</td>
<td>Privatization of hospitals main investor Hospinvest</td>
<td>Privatization</td>
<td>Unorganized Employees</td>
<td>Employees of the hospital has protested with strikes and slower work</td>
</tr>
<tr>
<td>2010</td>
<td>Decree that obliges residents participating in the professional trainee program (the only way to become practicing doctor) to spend equal time of work in Hungarian hospitals as the length of their training</td>
<td>Training</td>
<td>Hungarian Association of Residents</td>
<td>understood this as they have to work in the very same hospital</td>
</tr>
<tr>
<td>2011</td>
<td>Newly introduced provision enabling the employer to dismiss the civil servants without any justification</td>
<td>labor security</td>
<td>Various public employee unions</td>
<td>Protests</td>
</tr>
<tr>
<td>2011</td>
<td>Lack of wage normalization</td>
<td>Wage</td>
<td>Hungarian Association of Doctors</td>
<td>No voluntary over hours work done, as a support to the residents’ action on resignation letters</td>
</tr>
<tr>
<td>2011</td>
<td>Lack of wage normalization</td>
<td>Wage</td>
<td>Hungarian Association of Residents</td>
<td>Residents (approx. 2500) put their resignation letters until the end of the year pending completion of wage raise</td>
</tr>
<tr>
<td>Year</td>
<td>Description</td>
<td>Sector</td>
<td>Organizations</td>
<td>Action</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>2012</td>
<td>According to a new legislation all public servants who are in retirement age can only receive one source of income either pension or wages. By default retirement age public servants have to effectively retire unless they expressly request continuation of their work from the Ministry of Human Resources. Requests are assessed on a case by case basis and are only allowed in case of positions essential for safe healthcare provision. Approx. one third of the cases applied for the continuation of the work. Even if employees are allowed to continue working they have to renounce their pensions. In 2013 approx. 6500 employees were affected. According to GYEMSZI in one year (2013) the number of retirement age doctors has decreased with 37%, health care professionals with 64% other healthcare employees with 85%</td>
<td>Wage</td>
<td>Various public employee unions</td>
<td>Protests</td>
</tr>
<tr>
<td>2013</td>
<td>Acceptance of parasolvency can be punished up to 3 years of prison. In case the employer hospital in its operation policies allows the acceptance of parasolevency it brings no consequences, in case it doesn't it brings both labor law and consequences and prosecution. According to GKI in 2014 in Hungary 21 billion HUF</td>
<td>Wage</td>
<td>Hungarian Association of Residents</td>
<td>The Association asked the Prosecutor's General Office to issue their understanding of the law. Whether acceptance of unsolicited parasolvency after the health intervention is to be handled as bribe therefore to be prosecuted</td>
</tr>
<tr>
<td>Year</td>
<td>Reform Initiative</td>
<td>Global</td>
<td></td>
<td></td>
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<tr>
<td>------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>No special reform initiative</td>
<td>Hungarian Association of Doctors, Hungarian Association of Residents, Association of Unions of Medical Universities, Independent Healthcare Union</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Protest initiated at European level willing to raise awareness of the lack of financing of the health sector

*Sources: Weborvos.hu; Magyar Narancs; hvg.hu; rezidens.blog.hu; webbeteg.hu; origo.hu; Népszabadság Online; Economic Healthcare Reforms*
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