HEALTH SYSTEMS IN TRANSITION IN CENTRAL AND EASTERN EUROPE

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ABSTRACT

On 1 May 2004, eight former communist countries of Central and Eastern Europe joined the European Union (EU). This created a range of challenges for health policy in the new member states. On top of issues relating to the health of their populations, their economic situation, and the changing nature of healthcare that affects all countries, the process of acceding to the EU requires them to adhere to the accumulated body of European law, some of which has implications, directly or indirectly, for health policy. This paper examines these challenges and the responses being developed to them. While the countries have much in common, in particular the shift from the former model of healthcare financing to a more pluralistic model, often based on health insurance, there is also considerable diversity, as each is using different policy options to achieve the same broad objectives. While these countries have much in common, not least the experience of EU accession, they also have considerable flexibility to pursue the systems that they choose. The challenge is to enable a process of mutual learning without imposing a single, homogenous model that ignores their important differences. In doing so, they should not just look to the systems of healthcare being adopted by their neighbours in this region and to the models existing in the countries of Western Europe, but instead should be looking to the systems that they will have to put in place to meet the specific health needs of their own populations, which are different from those in other parts of Europe, as well as to meet the challenges of the future.

INTRODUCTION

In less than 15 years, the countries of Central and Eastern Europe have undergone a major transition, from centrally planned, socialist economies in the 1980s, to becoming members of the EU on 1 May 2004. This paper seeks to provide an overview of some of the issues facing those involved in the governance of their healthcare systems. It begins by reviewing the context within which reform is taking place, so reflecting on some of the issues that each country faces. It then asks whether, among these countries, there is some convergence in the pathways that they are following, towards a common model of healthcare, as some have argued, or are they in reality quite different, implying that they must pursue different policies if they are to respond effectively to the challenges that they face.

THE CONTEXT OF TRANSITION

National differences

It is first necessary to look at the context of the transition that this region has gone through, starting in the 1980s. Even at that time, when nearly all of these countries were within the Soviet bloc, or even, in the case of the Baltic States, in the Soviet Union, there was quite considerable national diversity. Some, such as the German Democratic Republic, were relatively wealthy, with high levels of industrialisation, producing technology that was in demand on world markets. Others, such as Romania and Bulgaria, remained relatively under developed, particularly in rural areas. Each country differed in its openness to the rest of the world. Many Hungarian health professionals had the opportunity to obtain training abroad, and so were exposed to modern scientific developments and, in particular, to the emerging culture of evidence-based healthcare. In contrast, foreign travel was virtually impossible for health professionals living in Romania, where few, if any, Western journals were allowed into the country. Countries differed greatly in their openness to internal debate. Again Hungary, with its goulash communism, or Poland, with an increasingly vocal opposition in the form of the Solidarity union, may not have been fully fledged democracies but at least tolerated a relatively open discussion. In contrast, the Stasi in the German Democratic Republic[1] and the securitate in Romania[2] had created enormous networks of informers monitoring almost everything that happened. So even at this stage, there was considerable diversity among superficially similar countries.

The nature of transition

The nature of the transitions that took place at the end of 1989 also varied. Some, such as those in Hungary and Czechoslovakia were essentially peaceful. The changes in Romania were accompanied by bloodshed, symbolised by the graphic photographs of the executed bodies of Nikolai Ceausescu and his wife, which flashed around the world that Christmas day.

It was inevitable that the legacy of the past and the struggle for freedom would shape attitudes to the future. Most obviously, there was a widespread rejection of the collectivist approaches of the communist period. Individual freedom, including the freedom to make mistakes, was valued in its own right. There was also a strong desire to redress some of the failings of the communist healthcare system. In particular, there was a

demand for transparency of funding. At least in theory, the healthcare system was one of the triumphs of the communist system, providing universal coverage and, in the immediate post-war period, it did have many successes, in particular bringing basic healthcare to the entire population, yet it was unable to keep up with developments in the 1970s and 1980s. The general economic decline, coupled with a shift of funding away from the social sector (sometimes referred to as the non-productive sector), to heavy industry and in some countries to defence, meant that earlier gains were being lost. In these circumstances, the argument that the healthcare system could continue as it had been organised in the past was simply not tenable. Whatever was put in place had to be different.

Towards EU membership

The transition was also shaped by the changing political agenda after 1993. In that year the members of the EU, meeting in Copenhagen, agreed to a major eastward expansion. They set out a series of criteria that had to be met before other countries could join.[3] These were: the development of stable institutions that could guarantee democracy, the rule of law, human rights, and in particular the protection of minorities. Here they had in mind the Roma (or gypsy) minority, a group that has been persecuted for many hundreds of years, but which did receive some degree of protection during the communist period.[4] The Roma population form significant minorities in several countries in Central and Eastern Europe, in particular Hungary, the Czech Republic, Slovakia, Romania and Bulgaria. Unfortunately, in the new situation that arose after 1990, especially where nationalist politicians were seeking scapegoats for the economic ills that their countries faced, there was growing evidence of discrimination and worse.

The second criterion was the development of a functioning market economy, with the strength to participate fully in the European single market. The third criterion was the ability to take on the obligations of membership of the EU, in particular adherence to the Economic and Monetary Union. These broad goals were to be underpinned by a package of quite specific actions, many involving the adoption of the existing body of EU legislation, known as the *acquis communautaire*.

The disadvantage of joining something late, as the UK should know, is that one has to accept all of the decisions made by those who got there first. As a consequence, the newly joining countries have to pass into national law the accumulated provisions of the European treaties, the regulations and directives that arise from them, and the judgements of the European Court of Justice. There are virtually no opt-outs from this, and European law takes precedence over national law.

What does EU membership mean for health?

So what are the implications for health? This question is remarkably difficult to answer. The problem is that matters related to health are covered by many different parts of the European Commission. This can be seen by looking at the list of chapters in the *acquis communautaire*. Free movement of goods includes medical technology and pharmaceuticals, free movement of persons includes patients and professionals, and the freedom to provide services includes health insurance. Competition policy has implications for the organisation of healthcare funding and delivery, especially in those countries that have established competing funds or providers. Agricultural policy has major implications for rural development and for the types of food that are produced and therefore available for the population. Transport policy impacts on health through vehicle emissions, road safety and access to services in rural areas. Taxation is increasingly seen as an important element of policies on tobacco control. Social policy and employment covers aspects of the funding of healthcare, especially in countries where there are social insurance systems or where healthcare is linked to an individual's employment. Industrial policy impacts on the pharmaceutical industry. And one could easily go on through all the different chapters, finding some health-related issues under almost all of them. One that should, however, be mentioned is number 23, covering consumers and health protection. This is primarily adoption of the EU's public health policies, in areas such as the response to epidemiological emergencies, the exchange of good practice, and policies on the determinants of health, such as smoking.

Enacting this massive body of law has preoccupied national governments for several years. In effect, the agenda for EU accession has dominated the political processes in most of the candidate countries. This major process of reform has obviously brought many benefits, but it has also made the process of healthcare reform rather more complicated. Because there is no single chapter dealing with healthcare, health policy makers must search diligently throughout the entire body of EU law to find those areas that affect them.[6] Sometimes this means that laws get passed without adequate consideration of their implications. An example is the recent Estonian law on data protection, which was passed by the Estonian parliament with only 26 out of its 101 members present, and which contains none of the provisions adopted elsewhere to allow for exemptions for public health and medical research. As a consequence, unless the law is in amended, the Estonian Cancer Registry, a unique national resource, will be unable to continue working.[7]

It means that those introducing reforms need be especially careful that they do not stumble accidentally in directions that they would not choose to go. This is

something that the UK has considerable experience of, facing the prospect of radical change to its hospital systems as a consequence of the working-time directive.[8]

The changing nature of healthcare

Healthcare has changed beyond all recognition over the last 30 years and is now much more complex than it was in the past. First, patients are more complex. With ageing populations, more people have multiple chronic diseases. They are receiving new and often potent treatments for these diseases. However, because they have several co-existing disease processes, each may be taking a combination of drugs that, together, have never been the subject of any evaluation of effectiveness.

Treatment settings are also changing beyond all recognition. The model of healthcare that has been dominant during the twentieth century, based around large hospitals where operating theatres, laboratory facilities, and imaging equipment were concentrated, is facing a major challenge.[9] Shorter acting anaesthetics and minimally invasive surgical techniques mean that operations can be undertaken in many places outside hospitals. Near patient testing is challenging the rationale for centralised laboratories. New methods of imaging, such as ultrasound or mobile CT scanners, are challenging the rationale for large X-ray departments. One cannot, therefore, assume that the existing model of healthcare will be the most appropriate to meet the needs of our populations in the twenty-first century.

Moving forward

The context within which healthcare reform has been taking place in Central and Eastern Europe can be seen to involve at least three considerations. The first is the legacy of the past, with its sustained under investment in healthcare and unresponsive services, but also the political imperative of having a break with that past and rejecting any of the ideas from the communist era. The second is the process of EU accession. This is clearly a major driver of policy in many areas in the candidate countries, although its impact on healthcare is far from straightforward. The third is the changing nature of healthcare. This is a worldwide phenomenon and is certainly not limited to the countries in transition. It is important because it shows that the model of healthcare in Western Europe almost certainly is not what is appropriate for the future. Consequently, countries should not be trying to catch up with the West but should be trying to overtake it, to move to a model of care that is more appropriate for the twenty-first rather than the twentieth century.

THE FUTURE OF HEALTHCARE IN THE NEW EUROPEAN MEMBER STATES

The second half of this paper raises three important questions. The first is – what are the factors that are driving healthcare reform in the candidate countries? The second, following on from this, is to identify whether there are identifiable paths being followed with regard to the organisation and funding of healthcare? Finally, how do the requirements of the accession process affect the development of healthcare policies?

Factors driving reform

There are two competing hypotheses that might help explain the pattern of reforms to the different healthcare systems in the candidate countries. One is the hypothesis of convergence. This stresses the importance of a series of factors that are driving healthcare systems in the same direction. The first is the introduction of market forces, something seen in all of the transition countries to a greater or lesser extent. This largely reflects the imperative of moving away from the systems that were in place during the communist era. The second, which has been termed 'European-isation', reflects the way in which those working in healthcare systems have become fully engaged in the debates taking place within the rest of Europe about the future nature of healthcare and how it should be delivered. The third, already discussed briefly, is the importance of preparing for the accession process. Taken together, these suggest that healthcare systems are moving along a common pathway towards what is termed 'modernisation'. There is an emphasis on the impact of the European dimension, and a stress on the common challenges faced by each of the candidate countries. The hypothesis predicts the adoption of similar strategies to cope with these common challenges.

The second hypothesis is that of institutional diversity. It argues that national policies and institutions are remarkably resilient to external forces. It emphasises the importance of factors promoting divergence, such as differences in geography or social structure or cultural values, as well as histories and economic conditions. This paper has already alluded to the many differences that existed between the different countries in this region during the post-war period. It is possible to go back even further to look at the very different traditions of those countries that were at various times parts of the Austro-Hungarian, Turkish, German and Russian empires. The period since 1989 has also been characterised by a considerable political diversity. For example, the early 1990s in the Czech Republic were characterised by a free market approach, drawing heavily on the ideas of Margaret Thatcher.[10] In Hungary, the direction of reform changed as different political parties came to power with each general election. The challenges of institution building were especially great in Romania and Bulgaria,[11] so that reform was delayed long after change had taken place in their neighbours. As a consequence, this hypothesis stresses the variety of health policies and strategies seen in the different candidate countries.

Both of these theories have something to offer. Consequently a mixed perspective seems appropriate. This makes it possible to look at the similar challenges faced by health policy makers in each country and to see how they explain similar patterns of development and healthcare systems. At the same time one must be aware of the very diverse contextual factors that shape policy making in each country and also understand the way in which the characteristics of the country lead to variations in the outcomes of policies that may actually be quite similar.

Common challenges

The first step is to look at the common challenges that the countries of Central and Eastern Europe face. The logical place to begin is with the health context.

Population structures

Some of the challenges are common to all industrialised countries, such as the ageing of populations, although here the challenge is rather greater than it might otherwise have been. Despite the high levels of premature mortality, which means that fewer people reach old age than is the case in the West, the precipitous reduction in the birth rate across this region means that the dependency ratio is increasing rapidly. This has important implications both for pensions and for the ability to fund healthcare in the future. The greatest immediate challenge is from the very high level of non-communicable diseases. At the risk of oversimplifying the problem, one can identify three immediate causes for this. These are the high levels of smoking, hazardous alcohol drinking and poor diets. Looking ahead, the outlook is somewhat mixed. The opening of borders and the development of a modern retail sector has meant that the variety of food in the diet has increased greatly. In particular there is much greater access to fresh fruit and vegetables and to vegetable fats. It seems that this is the main reason behind the marked decrease in deaths due to cardiovascular disease, an improvement that took place almost immediately after the transition in Poland[13] and Czechoslovakia, although delayed by a few years in Hungary and later still in Bulgaria and Romania. On the other hand, this region is subject to a massive onslaught by the international tobacco companies.[14] It can be predicted with confidence that this will have a catastrophic impact on the health of women in the future, as their rates of smoking increase. Unfortunately, some countries have yet to grasp the scale of the challenge that they face. On the other hand, some countries, such as Poland have been in the forefront of the fight against the tobacco industry, enacting wide-ranging policies that go beyond the requirements of EU legislation.

It is impossible to discuss non-communicable disease in this region without mentioning alcohol. Two patterns can be discerned, with the northern countries such as Poland and the Baltic states, experiencing high levels of alcohol-related injuries and sudden cardiac death,[15] while a band of countries stretching through Slovenia, Hungary and Romania into Moldova have some of the world's highest levels of alcoholic liver cirrhosis.[16]

Communicable diseases

At the same time there has been a re-emergence of other infectious diseases that were thought to have been conquered. Rates of sexually-transmitted infections have increased almost everywhere, fuelled by an explosion in the sex trade. Changing patterns of land use are contributing to increases in tick borne encephalitis in the Baltic states[17] and leptospirosis in Bulgaria.[18] Tuberculosis has returned and with a vengeance, it is now resistant to many first-line drugs.[19] But it is not only old infections; although rates of HIV infection are still relatively low on a global scale, the rate of increase in this region is one of the fastest in the world.[20]

Life expectancy and avoidable death

One way of looking at health system performance is to track changes in levels of what is called avoidable mortality. This is a measure that captures deaths that should not occur in the presence of effective and timely treatment, for example deaths from diabetes or hypertension among young people.[21] Death rates from these causes are still much higher than they are in Western Europe, showing just how much still needs to be done.[22]

The overall impact of these factors can be seen by looking at life expectancy at birth, an aggregate measure of the overall health of the population. As Figure 1 shows, although the gap with the EU average is slowly narrowing, it is still unacceptably wide for some countries, and, taken as a whole, if current trends are projected forward, the gap will not close until at least 2030.

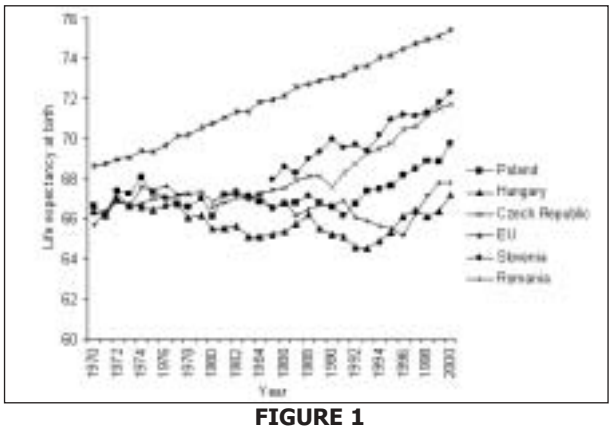

FIGURE 1

Male life expectancy in selected candidate countries and the EU. Source: WHO HFA database.

Macro economics

A second challenge each country faces is the macro-economic situation. Each faces severe fiscal pressures, leading to a lack of resources for healthcare. The situation is exacerbated, as it was in Western Europe in the early 1990s, by the need to meet the requirements of the European Monetary Union, and in particular the requirement to keep public sector borrowing low.[23] At the same time the opportunities to raise funds for healthcare are limited by the size of the informal economy, which inevitably lies outside the reach of the tax authorities.

The relative performance of the countries in relation to the EU can be seen in Figure 2. The early years of the 1990s were characterised by an economic recession throughout this region. This, coupled with low rates of economic growth during the 1990s, mean that the distance from the EU, which was already very wide 15 years ago, has widened further. Even Slovenia, the wealthiest of the candidate countries, has a level of economic performance that is less than half of the EU average.

Healthcare and its delivery

A third set of common challenges arise from the pressures for change in the way that healthcare is organised. Reflecting the widespread rejection of centralised power in the past, there has been sustained pressure for increased democratisation of the governance of healthcare. As a consequence, hospitals and other healthcare facilities in many countries have been transferred to local government control.[24] This has the benefit of bringing them nearer to the population that they serve. However, it also has the drawback of reducing the opportunities for planning major capital investments at regional level. In the delivery of healthcare, in common with all other aspects of society, there is pressure to be much more responsive to the needs of the consumer. Older systems of medical paternalism are no longer acceptable.

A fourth common challenge relates to the changing delivery of healthcare. It is now widely agreed that the communist model, while bringing benefits in the immediate post-war period, also had serious weaknesses. In particular, primary care had a very low status, and systems of referral in both directions between primary and secondary care were poorly developed. Budgetary systems, based on line-item budgets, provided no incentives for greater efficiency. The low cost of labour, with health professionals receiving salaries that were often less than the average in manufacturing industry, created no incentive to invest in technology that might save the need for high staffing levels.[25]

The final set of challenges return to the issue of accession to the EU. This is potentially an enormous topic that cannot be dealt with here but is examined in detail elsewhere.[26] The major challenges relate to the freedoms that are enshrined in European treaties. Free movement of persons provides for movement of both patients and professionals. It is unlikely that there will be any large-scale movement of patients, but there are much greater concerns about the implications for

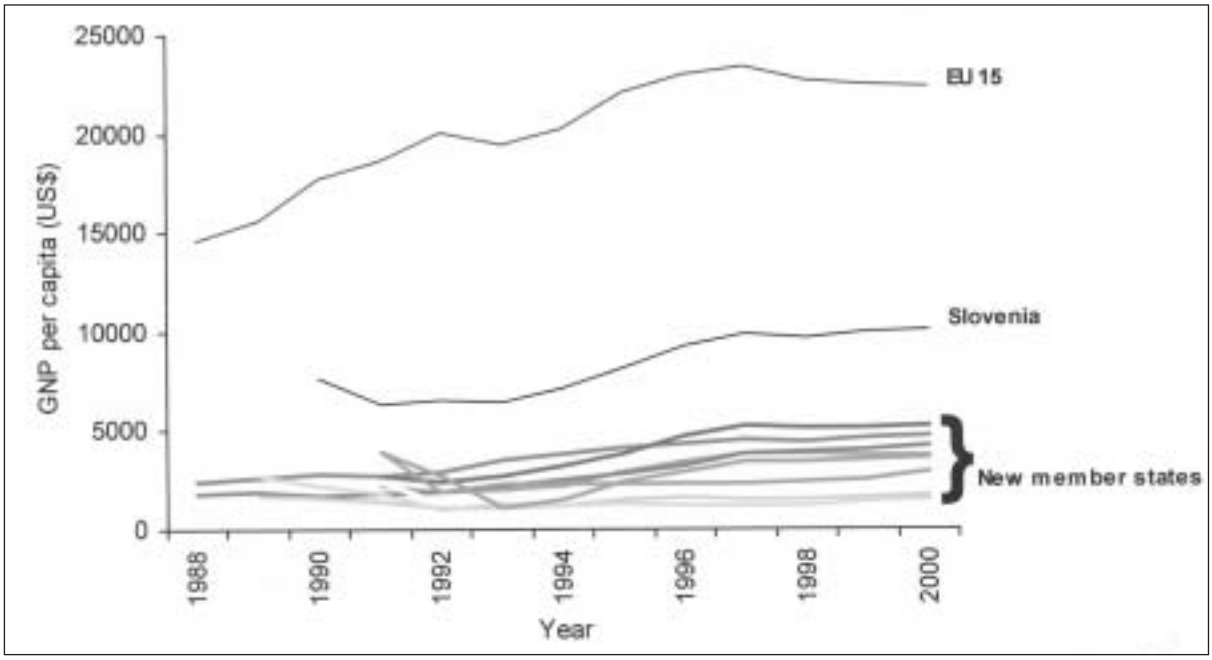

FIGURE 2
Economic trends in EU. Source: WHO HFA database.

movement of professionals, given the very large differentials in salaries between the two halves of Europe, as well as the impending shortage of physicians in many Western European countries. It would be complacent to think that current relatively low levels of professional mobility will continue in the future. There must be a real concern that some candidate countries might lose a significant number of their graduates each year.

Common responses?

Given all of these common challenges, is it possible to detect any commonality in the responses that countries have developed? To some extent, yes. In most countries one can discern some evidence of strengthening of public health capacity. It is widely recognised that the sanitary epidemiological system was inappropriate for the challenges that are faced. New models of public health, addressing more effectively the broader determinants of health, have been put in place in several countries. These need to be supported by new training programmes and here one might single out the example of Hungary as a model of good practice.[28] Each country has reformed its healthcare financing, moving away from the old system, based on what was often referred to as the residual principle, in which what was left over after all other priorities had been met was allocated to healthcare. At the same time the sources of funding have diversified. This has been linked to the creation of a more pluralist model of healthcare governance. New methods have been introduced to pay providers, such as Diagnosis Related Groups and other measures based on levels of activity. There have also been a wide range of new regulatory and legal measures on topics such as pharmaceuticals and health professionals, largely as a consequence of the need to adopt EU law.

On the other hand, there are also many differences. As noted earlier, countries differ in their history, their geography, their political systems, and their economic status. Countries also differ in their political orientations. The open, free-market policies adopted by Vaclav Klaus in the Czech Republic can be contrasted with the nationalist policies adopted by the Meciar administration in Slovakia or the conservative policies pursued by successive Bulgarian governments.

Another factor was the interest shown in specific foreign models. Sometimes this was a consequence of study tours by key decision-makers. Sometimes it reflected the influence of particular foreign consultants working in a country. And sometimes it was because those involved in making decisions had personal experience of working in other systems, in particular in Germany. Inevitably, policy makers were influenced by the debates taking place within other countries. For example, there was little interest in pursuing a model along the lines of the American system, given its very obvious failings, with high costs yet a lack of universal coverage. Similarly, widespread discussion about waiting lists in the UK suggested to many that an alternative model was preferable. On the other hand, there was considerable interest in the British model of primary care, which was seen as having much to offer in terms of its gatekeeping function and holistic approach.

Then there is the impact of specific events. For example, the death of a family in a house fire in Hungary in the late 1990s attracted much attention from politicians, placing the spotlight on the organisation of emergency services.

Diverse responses

In practice, therefore, there are common challenges but often quite diverse responses to them. This can be seen with models of healthcare financing. Thus, many countries have adopted a form of social health insurance, although they differ in the time they took to pass the legislation and then to implement the system, the degree of government involvement, either in the management of the funds or their ability to set their own contributions. There were also differences in the roles played by the traditional actors: central and local government, employers and trade unions.[29]

A second way in which responses differ is the basis of entitlement to coverage. In some cases this is based on residence while in some cases it requires one to contribute to the fund. This obviously has implications for equity of access to care, especially in relation to migrants.

A third way that they differ is the degree of integration of financing. Some systems are fragmented, with multiple funds, as in countries such as the Czech Republic, Poland and Romania. However even here, the form of differentiation varies considerably, with different funds sometimes based on occupational groups and sometimes on geographical areas. On the other hand, some countries such as Hungary have adopted a single payer system.

Finally, they differ in the balance of funding sources. All countries have accepted the principle of universal coverage, something that ensures consistency with Western Europe but contrasts with the situation in the US. However, to do so it is necessary to draw some funds from taxation, to cover the non-working population as well as certain elements of healthcare spending such as public health, medical education, and sometimes capital expenditure. Even in countries with systems one might label social insurance there is often a considerable contribution from taxation.

Turning to the delivery of healthcare, again one sees considerable diversity in the models adopted. Some

countries have transferred ownership of their healthcare facilities to municipalities or to provinces, whereas others have retained them under central control.

CONCLUSIONS

In summary, the countries of Central and Eastern Europe face a similar set of challenges. These relate to the health of their populations, the economic situation that they face, and the changing nature of healthcare. In addition, the process of acceding to the EU requires them to adhere to certain common requirements, in particular the adoption of the accumulated body of European law. Some important developments are common to nearly all of the candidate countries, in particular the shift from the former model of healthcare financing to a more pluralistic model, often based on health insurance. However, there is also considerable diversity, as each is using different policy options to achieve the same broad objectives. Health policy making in the countries of Central and Eastern Europe is no different from that in Western Europe. The responses are tailored to the unique characteristics of each country. Each is a product of its own history and culture.

The implication is therefore that, while the countries in this region have much in common, not least the experience of EU accession, they also have considerable flexibility to pursue the systems that they choose. The challenge is to enable a process of mutual learning without imposing a single, homogenous model that ignores their important differences. In doing so, they should not just look to the systems of healthcare being adopted by their neighbours in this region and to the models existing in the countries of Western Europe, but instead should be looking to the systems that they will have to put in place to meet the specific health needs of their own populations, which are different from those in other parts of Europe, as well as to meet the challenges of the future.

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