

Health Reforms in Central & Eastern Europe since 1990: Comparative Context and Concerns

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Modern systems of social protection provide access to health care for citizens as a right. While the legitimacy and viability of nation-states are partly based on the provision of publicly financed health services, spiraling costs of providing care and growing demand for services are major factors for the rise in public deficits and for associated financial instability. Therefore promises regularly appear to reform the health sector by lowering costs, expanding access and/or improving the quality of care.

As a specialized subsystem of society, however, no national health system can be self-sufficient. It depends on external supports for several types of inputs. In cultural terms, its legitimacy is based on what a health system and its practitioners are allowed to do that is considered proper, acceptable, desirable or needed by the population. Its performance is grounded in techniques of knowledge in the art and science of medicine; consequently it requires personnel ranging from skilled professionals through paramedical technicians to ancillary staff. And its environment includes access to essential resources such as land, capital, infrastructure, instruments and drugs as well as subsidies, transfer payments and generation of revenue. With the exception of knowledge techniques that, once developed, can be used again and again without diminution, supply of these external supports is always limited and problematic. Because it absorbs limited resources – particularly in trained manpower and economic wealth, a health system necessarily competes with other subsystems in society such as education, investments, communications, defense and other non-health expenditures.

Despite these contextual limitations, the term ‘health reform’ trips teasingly off tongues of politicians and professionals who solemnly seek to resolve the dilemmas of national systems that try to deliver health care. Yet reform is a complex process embedded in empirical realities of power and privilege as well as economic constraints. Reform requires changes in form that is already entrenched in standard operating procedures as well as in habitual expectations and behaviors that are both well rooted and resilient. The chapters in this volume demonstrate a classic chronic gap between proclamation and implementation, between intent and result, between promise and performance in terms of access, quality and cost of health services.

This volume explores experiences with health reforms in selected countries of Central and Eastern Europe – all once members of the former Soviet Union or its orbit. After the fall of the Berlin Wall in 1989 and the dissolution of the Soviet Union in 1991, nations in the region engaged in extensive social and economic reforms that included major changes in their health care systems. Most reforms were examples of ‘panic policies’ that sought to expunge the communist legacy and, given external pressure from international donors, to move toward a market-based system without testing of what such a model entails. The authors of the following chapters examine the institutional legacies of their respective

national health care systems and their health reform efforts during the past two decades. In the policy-making arena, the authors describe the prevalent ideas, basic institutions and vested interests of a particular country as well as the role of external advisors during attempts to implement formal reforms. The chapters reveal that ‘policy’ includes not only formal statements of intentions but also efforts at implementation and the more or less permanent process of ‘after reform’ maintenance.

Based on categories outlined in the attached appendix, each chapter in this comparative study of health care reforms provides information and data at five-year intervals since 1990. For comparative enquiry, reform was defined as major shifts in decision-making power over the allocation of resources and in the distribution of financial risks in funding between as well as within public and private sectors (Björkman 2009; Okma and Crivelli 2010). As examples, such shifts include changes in selective contracting of health care providers, in authority over capital investments, in entitlements of public health insurance and in restrictions on medical decision-making imposed by practice guidelines. Decision-making power and financial risks can shift from the national level to regional and local governments (or vice-versa), or from governments to individual insurers and patients. All chapters address criteria for reforming national health systems such as effectiveness, efficiency, equity, cost and feasibility.

The case-study countries share institutional legacies of three erstwhile empires – Russian, Ottoman and Austro-Hungarian – that all ended in World War One. In many ways, post-imperial experiences of their successor states continue to shape contemporary behavior. Six of the countries are members of the European Union since 2004 – Hungary, Slovenia, the Czech Republic and Slovakia – and Bulgaria and Romania since 2007. Two countries – Macedonia and Slovenia – were constituent republics of federal Yugoslavia. And two – Armenia and Russia – are within the loosely structured Commonwealth of Independent States. Of the three countries in the ‘classical’ core of central Europe, two are successor states of Czechoslovakia that peacefully split in 1993. Most countries in this volume are, therefore, relatively young European nations with old political and institutional legacies.

Income levels range from middle-income (Slovenia and the Czech Republic) to relative poverty (Armenia and Macedonia). Demographics vary in terms of population size and urbanization as well as life expectancy and rates of maternal mortality. Russia has over twice the number of inhabitants than the other eight countries combined, yet it ranks second lowest in both life expectancy and government spending allocated to health – and has the highest rate of maternal mortality.

Table 1: Comparative Context of Countries (1990 – 2011)

Country	Populations (millions)		Population density/km ²		Percent urban	Per capita GDP (US\$)	
	1990	2011	1990	2011	2008	1990	2011
Armenia	3.5	3.0	124	105	64	637	3 033
Bulgaria	8.7	7.1	79	67	70	2 377	7 202
Czech Rep	10.4	10.2	134	134	74	3 748	20 444

Hungary	10.4	10.0	115	107	65	3 186	14 050
Macedonia	1.9	2.1	75	80	59	2 342	5 016
Romania	23.2	21.4	101	90	55	1 651	8 863
Russia	148.3	138.7	9	8	73	3 485	12 993
Slovakia	5.3	5.5	110	111	57	2 211	17 644
Slovenia	2.0	2.0	99	101	51	8 699	24 533

Sources: <http://data.worldbank.org>, www.unfpa.org, www.globalhealthfacts.org, www.cia.gov (various years)

As a percentage of GDP, government expenditure on health in all nine countries averages 4.8 within a range of two to seven percent. All countries face severe fiscal and budgetary pressures aggravated by expanding demand for health services and the dominant position of the medical profession that controls access to health care. Whatever else characterizes national health systems, their design and reform necessarily entail cost-control measures accompanied by mechanisms to secure the cooperation of health professionals (Freddi and Björkman 1988). During the past quarter century, the cost of providing health care has escalated throughout the world – and no less so in central and eastern Europe.

Table 2: Comparative Data on Health Care

Country	Government Expenditure (% of GDP)	Government Expenditure allocated to Health (%)	Government Expenditure on health (% of GDP)	Life Expectancy (years at birth)		Maternal Mortality Rate per 100 000 live births
	2010	2010	2010	1990	2011	2010
Armenia	28	6	2	68.5	69.1	29
Bulgaria	38	10	4	71.6	73.1	13
Czech Rep	44	15	7	71.4	77.2	8
Hungary	49	10	5	69.3	74.8	13
Macedonia	35	13	5	71.6	74.7	9
Romania	40	11	4	69.7	72.5	27
Russia	39	8	3	68.9	70.3	39
Slovakia	40	14	6	70.9	71.5	6
Slovenia	50	14	7	73.3	77.3	18

Sources: WHO 2012: www.globalhealthfacts.org

In several ways the pathways of health reforms in Central and Eastern Europe resemble those of industrialized nations. At its core, any proposal for reform seeks to modify the way arrangements are currently organized. Re-form seeks to change ‘form’ and, in so doing, to re-arrange the distribution of costs, benefits and valued resources. In the health sector, three issues regularly appear among proposals for reform – cost, access and quality; phrased otherwise, there are proposals for reforms in financing (revenue as well as expenditure), reforms in services (who gets what, when, where, how), and reforms in assurance that professionals are delivering competent care. Decades of experience suggest that reform isn't necessarily a good thing but reform, like beauty, is often in the

eye of the beholder. Because attempts at reform are inevitable as long as health care delivery systems remain problematic, this volume explores experiences in selected countries of central and eastern Europe – all formerly within the Soviet orbit or its Balkan variant. Each chapter reviews efforts to reform the health sector within (and sometimes beyond) available resources and capacity.

Reform has been on the international agenda for decades as approaches to reform evolved in fields well beyond health care (Whyte 2004). The 1950s and 1960s were characterized by ‘Institution Building’, an approach that focused on individual organizations. These organizations were modeled on – if not directly transferred from – so-called ‘developed’ countries. During these decades many public sector institutions were initiated, including state-owned enterprises with a strong emphasis on state-based delivery of social services. By the late 1960s and early 1970s, the emphasis on Institution Building had softened into concern for strengthening institutions that already existed. This shift to ‘Institutional Strengthening’ sought to provide tools that would improve performance rather than to initiate wholesale change.

During the 1960s and 1970s great reliance was placed on the role of government agents, particularly civil servants, for achieving strategies intended to reach neglected target groups and to improve delivery systems in order to reach such targets. Development was increasingly focused on people rather than on institutions and, during the 1980s, the key sectors were education and health care. Structural Adjustment appeared as a composite of policy reforms that were based on requirements or ‘conditionalities’ of economic and social changes by the recipients of donor funds. Capacity building broadened to include private as well as associational efforts in addition to government action, and there was greater attention to the international environment as well as national economic behavior. In the 1990s a paradigm of ‘governance’ emerged that re-united public administration with political participation. The 1990s were also characterized by reassessments of technical cooperation and its limitations, plus the emergence of local ownership as a vital factor for sustainability.

In the first decade of the 21st century, internationally endorsed Millennium Development Goals became a key driver for change based on results-oriented management and long-term investments. The age of the ‘quick fix’ has been replaced by an appreciation of the ‘long slog’. Emphasis is on knowledge-based networks that emphasize continual learning as well as on synergistic adaptation through participation by non-government actors in building capacity. A striking feature of the new forms of public-private collaboration is the focus on private entrepreneurship and modern management techniques based on high expectations about the benefits of information technology.

For several decades, public sector reforms have been premised on the assumption that improving the ability of government to manage its business will lead to improved social and economic progress. The first generation of reforms sought to cut public expenditures and to revive the private sector. Measures included budget cuts, tax reforms, limited privatization, liberalization of prices and, most conspicuously, efforts to downsize the

public sector – the latter being almost invariably described as ‘bloated’ and in need of surgery followed by a strictly enforced diet.

It quickly became evident that the transformation of government would require a long time and that the savings from reduced bureaucratic costs would be insufficient to provide even basic levels of public services. A second generation of public sector reforms then sought to improve the efficiency and effectiveness of government. While the first generation reforms stressed downsizing, contracting and improved control over budgeting and public expenditures, second generation reforms advocated decentralization to sub-national levels, the creation of semi-autonomous agencies in the central government, and reforms of human resource management (recruitment, selection and training).

More recently the agenda for reform has refocused yet again as a third generation of reforms seeks to improve social outcomes through better service delivery. This strategy emphasizes sector-wide approaches, particularly in health and education, in order to produce a coherent program for delivery of services that involves both governmental and non-governmental organizations. While these generations of reforms are overlapping rather than strictly sequential, all reforms have been driven by a combination of external and internal agencies. Multilateral and bilateral aid entails conditionalities that require a (commitment to) change in governmental behavior before money can be transferred. In turn, national planning commissions and ministries of finance require line agencies to adopt reforms that may include a combination of these generations.

Public sector reforms range across a repertoire of policy instruments: streamlined budgets, staff reductions, raised tariffs, contracting out and other forms of privatization. Reform of the health sector has focused on four main options, none of which is mutually exclusive, and all of which may occur at the same time. These are the establishment of autonomous organizations, the introduction of user-fees, contracting out of services, and the enablement and regulation of the private sector.

Most countries share basic goals in health policy: universal (or near-universal) access to health services, equity in sharing the financial burden of illness, and good quality health care. Given the growing share of public money in funding health care, governments have become concerned about efficiency and cost control. Patient satisfaction, patient choice and the autonomy of professionals are important goals too. Yet despite the similarity in policy goals, national arrangements for financing health care vary widely. The sources of financing for health care are general taxation (in the United Kingdom, Scandinavia and until recently most countries in Central and Eastern Europe), social health insurance (e.g., Germany, France, Japan and increasingly in Central Europe) and private health insurance (employment-based health insurance in the USA, and higher income groups in Germany and Australia that opt out of the public system). Direct cash payments are important, too, through out-of-pocket expenditures and through co-payments or deductibles. Often, however, governments mitigate the effects of user-fees by exempting specific groups such as the elderly and chronically ill patients or low-income families. In low-income countries external aid supplements national resources.

Variations in funding and contracting models in health care can be traced to country-specific historical developments but two events in Europe play a crucial role as models for policy. The first was the introduction of mandatory social health insurance for industrial workers and their families in Germany in 1883. Several countries in Europe – and others in Asia and Latin America as well – followed the German example of state-sponsored (but not state-administered) mandatory social insurance to protect the family income of industrial workers against the risks of illness, disability, unemployment and old age. The mandatory membership enforced by social insurance meant that the so-called ‘sickness funds’ had stable revenue streams and could create wider pools of shared risk. In the 20th century, these nongovernmental funds became core actors in the public policy arena by sharing the responsibility for social policy-making but under ever-greater government regulation.

The second major innovation in the funding of health care was the establishment in 1948 of Britain’s National Health Service. The NHS extended the German insurance model by providing coverage to the entire population with costs paid out of general taxation. While hospitals were nationalized, family physicians remained independent as practitioners. During the first half of the 20th century, many European countries followed the German example by establishing separate income protection schemes for certain groups in society (e.g., disability and unemployment benefits for industrial workers). Only after World War II, however, did the full range of modern welfare state programs appear including old age pensions, disability and unemployment benefits, health insurance, sickness pay and child support. In the first decades of post-war reconstruction, there was popular support for this expansion of state-sponsored schemes. By the end of the 20th century, funding for health care in most countries had become hybridized – that is, by adopting elements from both the British and German models. Employment-based arrangements for certain categories of workers were combined with population-wide and tax-based universal schemes.

After the oil crises during the 1970s, economic, demographic and ideological factors contributed to reshaping the popular notion of the welfare state from being a solution for social problems to being an economic burden and a cause of economic stagnation (Wilensky 2002). Economic stagflation with persistently high levels of unemployment meant that state revenues stagnated or declined while public expenditures continued to grow. Moreover, as the end of the post-war baby boom became visible, demographers had to revise their earlier demographic projections downward – and future pension outlays upwards. In addition, ideological views about the role of the state had gradually changed. On both the left and right of the political spectrum, critics agreed that state powers had become too intrusive in the lives of individuals. Growing discontent over fiscal burdens and disappointing results of public programs, rising consumerism and patient advocacy groups claiming a stronger say in the allocation and organization of health care – all challenged existing arrangements for providing welfare.

Governments sought alternative models of governance to reduce the dominant role of the state and to decentralize decision-making with more room for individual choice and

entrepreneurial ideas (Cutler 2002). Some countries took hesitant steps to introduce market competition in health care by reducing state control over the funding and planning of health care services. They also sought to broaden patients' choice of provider and health plan. Other countries turned to traditional tools of controlling public expenditure by setting strict budgets, reducing the scope of public insurance and increasing direct patient payments.

As chapters in this volume illustrate, health sector reforms have a significant parallel with civil service reforms. In most cases, reforms have been stimulated by economic recession and by severe fiscal problems in the state treasury rather than by an ideologically driven taste for reform. Declining budgets have adversely affected service delivery, even in countries that previously had reasonably well performing public health services. Central Ministries of Finance and Planning initiated reforms, and Ministries of Health struggled to respond to policy directives outside of their control. Economic realities of recession and fiscal crises affect not only the types of policies being implemented but also reactions to them by the users, beneficiaries and citizens. Given endemic economic crises, the stage of raising revenue through the introduction of user-fees in order to supplement budgetary resources is critical for governments. But the success of the policy, no matter how logical in theory, has been constrained by the dwindling capacity of citizens to pay for health care. Furthermore, the administrative cost of collecting user-fees and of monitoring exempted categories of users often exceeds the revenue collected. The initial reform, however well intended, had not considered inevitable transaction costs.

While reforms have been widely espoused in international arenas well as by technical experts, their implementation has been much more limited. It is difficult to assess the real potential for reforms in the health sector because more time is needed for assessment. Rather ironically, too, countries with the most radical reform agenda appear to be those with the least capacity to implement them; as Caiden and Wildavsky (1980) commented caustically some decades ago about planning and budgeting: the smaller the capacity, the greater the ambition, and vice-versa. Perniciously the depth of the economic recession in such contexts requires a radical approach in terms of policy pronouncements, yet reduces ability to implement such a radical agenda.

Proposed reforms face other barriers, too. One important constraint is the lack of skilled and motivated staff to provide services or administrative support. Organizations that traditionally favor hierarchy and command over initiatives and team development are unlikely to act on newly acquired formal autonomy. While the New Public Management emphasizes the importance of linking performance to rewards, parallel informal systems often undermine the formal reward systems. For example, promotions are often based on patronage and favors in the traditional patrimonial system, rather than on objective assessments of performance. Management information systems frequently fail to function effectively. Another significant obstacle is the lack of incentives for individuals within the health care sector to plan or to monitor their work in terms of the information that is produced. In other words, there is almost no feedback system for self-correcting action.

A further sign of weak capacity is poor coordination among different actors (Akukwe 1999). Governments experience great difficulty in translating broad policy statements into concrete strategies for implementation. As a consequence, there are problems in specifying and then enacting the details of decentralization policies. It is not clear, for example, as to the level of government at which financial rights and responsibilities lie. Likewise, it is not clear which organization should report which data to whom. These are all simple, but disastrous, problems in coordination.

Some of the constraints on capacity are, of course, rooted in the broader public sector rather than only within the Ministry of Health or similar agencies. Until recently, for example, all revenues generated from user-fees had to be returned to the national treasury – thus providing little incentive for their collection. Such a disincentive more or less ensured that such fees had zero impact upon the quality of health care. In contrast, when local hospitals are allowed to keep the user-fees that they collect rather than returning them to central coffers, not only do those hospitals have a better record for collection of fees but also they re-invest the surplus in such long-term benefits as higher quality equipment, more reliable stocks of pharmaceuticals and medical supplies, and even lower (or exempted) fees for the truly destitute (Björkman and Mathur 2002).

Both internal and external pressures for change encourage national governments to seek solutions and new ideas. This search fueled the growth of cross-national studies in the field of health policy. International organizations and consultancy firms became carriers of widespread but often ill-tested ideas. While comparative studies aim to analyze processes of health reform across the globe, a common problem is the facile assumption that policy as stated in law or formal government documents is the same as policy actually implemented. For many reasons, the outcomes of reform often differ greatly from the original policy intentions and statements. Faced with public discontent over unintended results, governments feel pressured yet again to adjust their policies and the cycle continues.

Empirical experience with goals and means for health reform indicate potential global convergence on patterns of performance, but countries implement change within their own institutional legacies and within the restraints of existing national institutions and political boundaries. The timing and speed of change of the health reform processes vary as well. In some countries, governments implement major change rapidly. In other countries characterized by strong opposition by organized state-holders, reform efforts are adjusted, delayed or even abandoned.

Combinations of core elements – funding, contracting (including payment modes) and ownership – determine the allocation of financial risks and decision-making power among the main players in health care. Government ownership and tax-funded services require strong government influence whereas private funding (insurance and direct patient payments) combined with legally independent providers restricts the role of the state even though governments can – and often do – impose rules to protect patients or safeguard the quality of and access to health care.

These terms help to characterize features of health care systems and policy-making but they do not explain the causes or the effects of policy change. In order to understand why countries embark on particular reform paths, one must investigate not only external and internal pressures for change but also structural features of social policy-making that enable politicians and policy entrepreneurs to change the system. However, institutional legacies and popular support for existing policy arrangements create powerful barriers to change.

In order to get reforms in the health sector on a sustainable track, structural changes need to be enforced. Such a track has to lead to outcomes that ensure minimum care for all citizens. Unfortunately, public hospital care in many countries has become unaffordable for the poor due to steep user fees. Additional hidden costs complicate this situation – ‘under the table payments’ to doctors being just one type. Subsidizing such a system, instead of reforming it, will only channel additional funds to the wrong (non-poor) recipients. Indeed, health sector reforms have been used as crutches to pretend that one is changing the system, but basically staying the course or even regressing. The issue is not whether people should share the costs because the people always end up paying. The real issue is who is to pay more and who is to pay less or nothing at all.

The next nine chapters examine arrangements for the delivery of health care services in selected countries of Central and Eastern Europe and efforts to reform them. Each chapter provides contextual information on the empirical realities of a specific country since 1990 as well as the organizational framework of its health care system. It then explores the historical thread of reforms attempted and their current state of implementation. While most countries keenly embraced recommendations of the World Bank, the World Health Organization and other international agencies or private organizations, few paid attention to the feasibility of such reforms. There were some policy innovations but also repetitions of mistakes that had occurred elsewhere. The cases reveal similarities of attempts during the post-communist era: high hopes and expectations followed by frustration and disillusionment. In reality, few nations abandoned existing institutions. Instead the new policy models added a layer of governance to old structures that did not disappear. While no blueprint is offered, intriguing patterns emerge across the selected cases that the concluding chapter identifies along with observations about the feasibility of ‘next steps’ in the unfolding process of health reforms in Central and Eastern Europe.

Appendix

Categories for collecting data and information in a comparative study of national health reforms through structured multi-country research; empirical data for systematic cross-country comparisons were sought at five-yearly intervals between 1990 (base-year) and 2010 (or the most recent year available)

1. Demographic characteristics
 - Geographic area (km²)
 - Population
 - Population density (population/km²)
 - Urban (percent)
 - Life expectancy at birth (male & female)
 - Infant mortality rate
2. Economic data (normalized with 1990 as base-year and converted into US dollars)
 - Total Gross Domestic Product (GDP)
 - GDP per capita
 - GDP growth rate (1980-1990, 1990-2000, 2000-2010)
 - Inflation rate
3. Health care expenditures
 - Outlays at all levels of government (audited)
 - Public outlays as percentage of total intergovernmental budgets
 - Private out-of-pocket outlays (estimates)
 - Total health expenditures (public + private)
 - Total health expenditures as percentage of GDP
4. Health resources (public, private, total)
 - Physicians
 - Physicians/100,000 population
 - Other health professionals
 - Other health professionals/100,000 population
 - Hospital beds
 - Hospital beds/100,000 population
5. Normative issues (descriptive assessment)
 - Cultural orientations (solidarity-individualism continuum; sectarianism)
 - Welfare principles (role of state: collectivist/residual; income protection)
 - Dominant values in health policy (by political party or faction)
6. Governance of health sector (descriptive assessment)
 - Main funding sources (taxes, private out-of-pocket, public/private insurance)
 - Contracting & payment models (integrated, competitive, selective)
 - Ownership mix (public, private, municipal, sectarian, self-employed)
 - Administration (degree of government control, centralized/decentralized, regulated, stake-holder involvement, public/private partnerships, neo-corporatism)
7. Major political positions, postures and trends (contextual & historical features)