chapter four

Health and health care in the candidate countries to the European Union: Common challenges, different circumstances, diverse policies

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Introduction

After successfully growing from six to fifteen members through four successive enlargements over the last half-century, the signature of the Accession Treaty in Athens has brought the EU to a turning point as it faces its fifth and greatest enlargement ever in terms of scope and diversity. Ten new Member States (Poland, Hungary, Czech Republic, Slovakia, Estonia, Latvia, Lithuania, Slovenia, Malta, Cyprus) will achieve membership on 1 May 2004, creating a substantial increase in its area, its population and its cultural and historic capital. But accession is more of a process than an event. Preparation for accession to the EU, which has also been initiated by Romania, Bulgaria and Turkey has created unprecedented pressures and opportunities for social, political, economic and institutional changes. The process of adopting the *acquis communautaire* and Copenhagen criteria has fundamentally altered institutions and policies in the candidate countries. To achieve membership, each state was required to show that it had stable democratic institutions, had made significant progress towards a functioning market economy, and had harmonized national regulations with the existing body of EU law, amounting to not less than 80 000 pages of legal text organized in 31 Chapters.

According to the European principle of subsidiarity, the organization, financing and delivery of health services is the responsibility of the Member States. Yet health care, which absorbs between 3% and 9% of Gross Domestic Product in the candidate countries, is far from immune from the requirements of the single European market. Health care has had a European dimension ever since the inception of the European Economic Community in 1957, in the Treaty of Rome. This is reflected in a range of health related legislation including, for instance, workplace safety, tobacco control and control of communicable diseases. However, the growth of European legislation in relation to the many components of health care, whether they be people (such as health professionals), goods (such as pharmaceuticals), or services (such as insurance providers) means that the health sector has not been spared the effects of the process of enlargement. The candidate countries have had to adapt their health systems to ensure conformity with a series of health related elements of the *acquis communautaire* scattered among many different chapters. Moreover, it is important to recognize that, for most candidate countries, the accession process coincided with the task of rebuilding or reforming their health care systems as part of the broader process of political transition and in response to changing health needs of their populations.

The purpose of this chapter is to summarize the main trends relating to the evolution of health and health care in the current candidate countries. Several questions are addressed. What factors are driving health care reform in candidate countries? Are there identifiable paths being followed with regard to governance and funding of health care? How do the accession process and EU imposed standards and regulations affect the development of health policies? Even though accession to the EU has been delayed to 2007 for Romania and Bulgaria and even longer for Turkey, the analysis will include all countries that have initiated the accession process: the two parts of former Czechoslovakia (the Czech Republic and Slovakia), three former Soviet states (Estonia, Latvia, Lithuania), four former independent socialist states of central Europe (Romania, Bulgaria, Poland, Hungary), one former part of Yugoslavia (Slovenia), and three Mediterranean countries (Cyprus, Malta and Turkey) As this list makes clear, these countries are very diverse in their historical inheritance and current status, yet they do, for the present purposes, have in common the imperative of adopting a wide range of EU legislative provisions.

The paper will proceed as follows. The next section outlines theoretical approaches that have been adopted to analyse the evolution of public policies within the context of European transition and integration. It highlights critical variables that must be taken into consideration to understand the transformation of health care in the candidate countries. A second section focuses on challenges faced by these countries in their transition process and reveals a series of broad commonalties that have implications for health care organization. A third section explores variations in health systems and demonstrates how differences in initial structural conditions and institutional developments are associated with differences in policy choices in various areas. It shows that, in spite of common imperatives related to accession, the re-engineering of health systems in the candidate countries is following quite diverse pathways. In conclusion, we synthesize the insights gained from this analysis. It is argued

that institution-building in the candidate countries is shaped by and embedded in the accession process. But health care systems as socio-historic constructions are characterized by a considerable inertia. While reforming their health services, candidate countries have to take into consideration both EU requirements and their national traditions and preferences. Overlooking the political, economical and institutional forces that operate at national level to channel changes in particular directions risks fostering creation of shallow institutions driven by short-term tactical considerations and designed only to satisfy external expectations. Restricting integration of the current candidate countries within a top-down, one-way process creates the risk of overlooking the potential contribution of the new members to the Union and may result in reversal of successful policies introduced by some countries before their accession.

Theoretical approaches to analysis of transition and integration

After the dislocation of the Soviet Empire and the collapse of the communist regimes in central and eastern Europe, the post-communist transformation has become a major theme of social science studies. At the same time, the processes of integration and enlargement by the EU have generated a rapidly expanding academic and policy interest in both Member States and prospective entrants. Although there is no enlargement theory per se, a coherent research agenda is being developed, building essentially on comparative analysis of pathways and outcomes of social and economic policies in the Member States and prospective members (Marrée and Groenewegen 1997; Grabbe 2001; Buller et al. 2002; Busse 2002a).

Theoretical approaches to studying European integration, EU enlargement and the transition of central and eastern European countries from socialism can be usefully placed into two main categories arising from two rival hypotheses:

The hypothesis of convergence emphasizes the prospect of transition to a market economy. A key contention underlying this hypothesis is that in embracing the western models of market economy and democratic polity, post-socialist and other transition countries are bound to converge to the supposedly superior systems and organizational forms of the industrialized West (Nee 1989; Dallago et al. 1992; Nelson et al. 1997). This means that the countries involved in the accession process were embarking on the same, clearly marked, road to the same final destination. Stabilization, liberalization and privatization of the means of production are promoted, all on a "one way" track, and representing an effective means to ensure efficiency of production, promote division of labour to maximize comparative advantage, ensure allocation of resources in line with consumer preferences, and avoid problems with incentives (World Bank 1996). Similar assumptions are also put forward in European studies which suggest that the twin processes of enlargement and integration of the EU generate a set of circumstances likely to induce convergence of national policies (European Commission 1995; Agh 1999a; Agh 1999b; Knill and Lehmkuhl 1999; Grabbe 2001). From this perspective, the different components of preparation for accession (technical assistance from EU, common programmes,

internalization of market standards, legislative harmonization, absorption of Phare funds, setting standards and monitoring applications over the course of accession) are all interpreted as mechanisms used instrumentally by the EU to ensure diffusion of western standards and drive prospective entrants towards greater convergence with policy models already adopted by the Member States. With regard to health systems, this means that a host of influences inherent in the accession process are likely to drive health services in candidate countries towards the standards of the West, in the expectation that this will make them more economically viable, responsive and compatible with a market economy. Comparisons with existing Member States, the influence of the EU and its conditionalities, and a willingness to overcome apparent shortcomings in health care delivery provided candidate countries with incentives to undertake major reforms of their health care systems and to come closer to western institutional and organizational configurations. In this respect, actions that have been taken in diverse areas such as health care financing, health care provision, human resource development, professional training and pharmaceuticals are often grouped under the label of modernization and interpreted as ways for the candidate countries to adapt their health care systems to a market economy environment and become more consistent with the Member States. Thus the accession process poses a set of common challenges for the candidate countries and makes them subject to many similar exogenous influences. The same criteria and procedures are applied by the EU to all current candidates. In parallel, at least in the former communist states, the transition process is forcing them to make the structural adjustments needed in order to regenerate their economies, modernize their health care systems, and take measures to improve the health status of their populations. Thus the overall contribution of this approach is to stress the impact of the European dimension and other exogenous pressures on the process of reshaping health systems in candidate countries. It notes similar strategies developed in these countries to cope with common challenges as well as imperatives created concurrently by the accession process and the need to reverse inherited shortcomings of their health care delivery systems.

The hypothesis of institutional diversity emphasizes the resilience of national policies and institutions to outside pressures and draws attention to the diversity of national circumstances. It puts forward the importance of path dependence, that is the ways in which cultural norms and inherited institutions combined with new ones leading to the emergence of hybrid institutional and organizational forms specific to each country (North 1990; Stark 1992; Magnin 1996; Nelson et al. 1997). Different transformation paths and different destinations are likely to be generated by different histories and different contexts. For the candidate countries, this means that their contrasting geography, social structure and cultural values, the different ways in which communism collapsed, and the diversity in initial conditions resulting from national historical events are all intervening variables that may explain different responses to similar pressures or imperatives. From this perspective, EU enlargement is defined as a complex systemic transformation process imprinted by the distinctiveness of national trajectories, and displaying general similarities and persisting national peculiarities. Because the EU candidate countries differ in terms of openness of

their economies, available resources, institutional history and development of their service sectors, they are likely to pursue distinct paths in the process of reforming their health services, notwithstanding similar pressures relating to the accession process. Applying the hypothesis of institutional diversity to the analysis of health care systems in the transition countries also suggests that expectations that a universal model of health care compatible with the market economy could replace the former arrangements are simply unrealistic. Diversity in initial conditions of candidate countries' health care systems, differences in domestic needs and capabilities, and unique political, social and economic conditions in each country would instead be reflected in diverse models of health sector reform. Furthermore, institutional configurations in the Member States constitute targets that are both multiple and moving (Hollingsworth et al. 1994). European health care systems, which already had adopted diverse institutional forms, have been undergoing significant changes over the last decade. Emerging configurations in the candidate countries are then subject to a variety of institutional influences and inspirations from the EU. In sum, this approach draws attention to the inertia that characterizes social structures and policies. It makes it possible to account for intervening variables such as economic, institutional and policy environments, which may generate different responses to the same exogenous pressures relating to the twin processes of accession to the EU and transformation of social institutions in the candidate countries.

Taken together, these two perspectives provide a potentially powerful analytical framework within which to analyse the evolution of health care systems in the candidate countries. The hypothesis of convergence offers a useful point of departure to examine similar challenges and pressures faced by health policy-makers in these countries which mostly share a common history of a planned economy followed by a transition to a market economy. The systematic attempts to harmonize rules and regulations with the EU, the political importance attached to membership by the candidate countries and the EU's determination to ensure compliance of the candidate with the *acquis communautaire* prior to their entry make a strong case for a commonalty of imperatives and possible convergence of the reforms being implemented. Concurrently, the hypothesis of persisting institutional diversity suggests that the convergence of policies, mainly macroeconomics, designed for a single market will not necessarily result in uniform health systems or health policies. Against a common background, there is significant scope for variation in the transformation processes among candidate countries and this is likely to be reflected in varied patterns of health care systems. Comparative studies of public policies have shown that similar challenges often manifest divergent constellations of problems in different countries. Policy choices and policy outcomes vary even among countries with similar features (Börzel and Risse 2000; Cowles et al. 2001; Héritier et al. 2001). Each country's characteristics defines the repertoire of feasible policy options. Thus, the accession process is only one variable among others. A complete picture must also take into consideration a broad variety of institutional, political and economic factors that influence the transformation of the health care systems in the candidate countries.

Common challenges faced by the candidate countries

As noted throughout this book, the 13 candidate countries are a diverse grouping although it is possible, with caution, to identify two main groups: a group of ten countries in central and eastern Europe (CEE) that share a common background of past socialist governance followed by a transition towards democratic polity and economic liberalization; and a second group of three Mediterranean countries (Cyprus, Malta and Turkey) historically characterized by a lower level of economic development than most western European countries but a long-standing tradition of openness to western influences, in particular in the cases of Malta and Cyprus, which have long been subject to British influences. But this sharp divide must not overlook the common features shared by all the current candidate countries. First, as emphasized by Agh (2003) throughout their long history, the countries of CEE have also been closely integrated with western Europe both in terms of trade and culture and prior to the imposition of communist rule most had democratic governments. Second, although the changes required to achieve the requirements of accession may have been greater for the states of CEE due to 50 years of communist rule, it remains the case that all the current candidate countries (and as the examples in this book show, countries involved in earlier enlargements) had some distance to travel in order to achieve the objectives of reforming their systems of social protection and implementing the fundamental legal, economic and political changes required for accession to the EU. Common challenges and trends shared by the 13 candidate countries relate to the health context, the macroeconomic context, the political organization of the health system, and the micro-efficiency of the health services.

The health context

Patterns of health in the candidate countries are examined in detail in Chapter 2. For the present purposes, the most important points to note are that, despite recent improvements, the burden of disease in the CEE candidate countries is substantially higher than in existing Member States, with particularly high levels of non-communicable diseases. Looking ahead, they face ageing populations as fertility rates have fallen below replacement levels in most countries. Only Slovakia and Poland have experienced an increase in populations over the last decade. The total population of the candidate countries, estimated to be about 105 million in 2000, has fallen by nearly 2 million over the last 10 years whereas life expectancy has shown significant improvements during the same period (WHO Regional Office for Europe 2002). This means that the expected costs of caring for an older population and of delivering effective treatment of chronic disease and disease prevention are emerging as key issues to be addressed by all the candidate countries. This will require health care delivery systems to meet new types of demands requiring high cost, highly specialized, technologically driven and multidisciplinary care. In some countries the situation is complicated further by the re-emergence of pre-existing infectious diseases that were thought to have been under control, in particular tuberculosis and syphilis.

The macroeconomic context

Financing of health systems has become one of the most critical challenges facing governments across Europe, leading to continuing debate about reform. However, in many candidate countries these pressures have become even more acute, prompting often radical reforms as a consequence of a series of factors including the past legacy of under-capitalization of health care infrastructure (particularly in the post-communist countries but also to a certain extent in Turkey and Cyprus), the temporary collapse of economies in CEE candidate countries in the early 1990s, the exacerbation of tensions between competing priorities during the accession process, and the importance of an informal or "shadow" sector as integral part of the economy in many candidate countries. Common challenges faced by the candidate countries in this respect are as follows.

The availability of resources for healthcare

With the exception of Malta and Slovenia, which allocate a share of GDP close to the EU average to health care, the candidate countries are in general perpetuating a situation in which they spend a relatively modest proportion of their national income on health care. According to the most recent estimations, the share of GDP allocated to health care averaged 6.2% in the candidate countries in comparison with 8.5% in the Member States (WHO 2002). Even more significant is the fact that six countries (Hungary, Bulgaria, Slovakia, Slovenia, Estonia, Latvia) out of the 13 candidates experienced a fall in the share of national income dedicated to health care between 1995 and 2000. Although public health expenditures still account for the most important part of total health spending, ranging from 53.8% in Cyprus to 91.4% in the Czech Republic, the general trend is towards reducing these proportions and looking for additional sources of funding. Thus private expenditure through direct out-of-pocket payments and voluntary health insurance have tended to increase in most of the candidate countries over the last decade (WHO 2002).

The size of the shadow economy

In most candidate countries, the size of the shadow economy, accounting for up to 33% of the labour force (Estonia) and 36% of GDP (Bulgaria) creates serious impediments to reforming health care financing and optimizing the use of health care resources (Schneider 2002; European Commission 2003). Informal and under-the-table payments have emerged as a significant proportion of health care financing, particularly in Estonia, Bulgaria, Latvia, Slovakia and Turkey where low levels and, in some cases, decreases in health care resources have led to underpaid staff, lack of basic equipment in public facilities and access to some basic services becoming dependent on capacity to pay informal charges. According to some estimates, the frequency of informal payments for health services may reach 60% in Slovakia, 31% in Latvia and 21% in Bulgaria (Lewis 2002). This shadow economy in health care has at the very least two important implications. First, under-the-table payments are reducing the

effectiveness of public policies since it is patient ability and willingness to pay that determines where resources flow into the system. Second, because a large shadow economy increases the risk of evading social contributions, it is incompatible with health insurance systems based on payrolls which have emerged as the predominant form of health care funding in the candidate countries, and which depend on high formal employment rates.

Adaptation of health care systems to the requirements of the single European market

A number of health related actions undertaken over the years by the EU to implement its single market policies have also altered the macroeconomic environment in which health care systems exist and have important implications for prospective entrants.

A first set of issues is raised by the opportunities offered to the health sectors in the candidate countries by elimination of barriers to free movement of goods. Manufacturers of medical devices and pharmaceuticals may be attracted to future Member States that have a competitive advantage due to less costly labour. But a prerequisite is the enforcement of international standards relating to intellectual property protection for such products. In addition, inherent tensions between the free movement of goods and diversity of pricing and reimbursement systems have led to the development of parallel trade. As shown by the experience of Spain's accession, medicines sold in acceding countries might be diverted to more lucrative western European markets, so reducing access to them in their original destinations (Lobato 2002). Joining the single market for health products also requires that most candidate countries close the gap with the EU in terms of quality, safety and efficacy standards and ensure that products produced under their jurisdictions meet the necessary international standards (Kanavos 2002). These issues are considered in more detail in Chapters 15 and 16.

A second set of issues is raised by the free movement of patients, especially since the Kohll and Decker judgements by the European Court of Justice. These, and subsequent rulings, have extended the right of patients to seek treatment abroad and clarified that health care provision is, in certain circumstances, considered as a service under European law and so subject to rules on the internal market. This gives candidate countries an opportunity to attract patients, and thus resources, from other Member States by providing cheaper services, while at the same time facing incentives to improve the quality of their services (Busse 2002b). However, the prospect of significant numbers of their own citizens seeking treatment abroad may pose a threat to the finances of their health care systems as the costs of care in current Member States are likely to remain higher for some time. These issues are addressed in more detail in Chapter 11.

A third set of issues is raised by the rules on free movement of professionals within the European single market. These have required candidate countries to update their legislation on professions and, in some cases, restructure training programmes (Cachia 2002; Zajac 2002). These developments have, however, been seen by some as threatening the possibility that a significant number of

highly qualified health workers in some candidate countries taking advantage of the single market to emigrate towards the more wealthy Member States. These issues are dealt with in more detail in Chapters 7–10.

The political organization of the health care systems

Countries across Europe face a common challenge of dividing competencies and powers between different administrative and political levels. At an EU level, the Treaty on European Union has confirmed the principle of subsidiarity, in which governance functions should be discharged at the lowest possible level of government. In the health sector, decentralization has emerged as a major thrust of health reform initiatives. Although facing increasing questioning about the appropriate balance between centre and periphery, it has been seen as an effective means of achieving a number of objectives such as to deliver services more responsive to local needs, improve democratic accountability, and create incentives for efficiency. The candidate countries have clearly followed this trend and the accession process has coincided with convergent efforts made in each state to transform the health sector in a less hierarchical and more decentralized system. In Malta, Cyprus and Turkey, decentralization is still an important component of the health reform agenda even though the changes have so far been relatively modest and have mainly involved a shift to a more pluralistic provision of health services (Aktulay 1996; Muscat 1999; European Commission 2003). In the ten countries of CEE, decentralization has been part of the systematic rejection of the communist model of health care governance, which was characterized by a strictly hierarchical structure and a centrally organized budget system, leaving no room for popular choice or local initiative (Afford 2001). A general pattern in health care reforms in CEE has been to devolve to local and/or regional authorities an increased role in provision and, in some cases, financing of health services. Other measures such as the creation of semi-autonomous health insurance agencies and limited privatization of ownership of health care facilities have confirmed the move from the previous centralized structures towards a more pluralistic system. However, while designing these new structures, the candidate countries have also been faced with a common set of emerging policy issues such as defining clearly the distribution of power and competencies among the newly created entities (central versus regional and local; owners versus founders; purchaser versus provider; public versus private), as well as containing costs, preventing irrational duplication, and minimizing disparities between regions (Belli 2001).

The microeconomic efficiency of health services

Microeconomic efficiency refers to both allocative and technical efficiency in the various parts of the health sector. The goal is to achieve a combination of services that minimizes cost while maximizing health outcomes within the resources available for health services. It requires a search for technological innovations, organizational reconfigurations, and combinations of inputs that

can most increase efficiency. In this respect, the candidate countries face the challenge not only of providing sufficient resources for health care but also to optimize the funding methods used and develop the most efficient arrangements for the provision of health services. The CEE countries inherited health care delivery systems characterized by labour rather than capital intensive provision and characterized by major shortcomings such as overprovision of poorly equipped hospitals, an emphasis on specialization, a vertical and segmented approach to disease management, underpaid staff with low status, and a lack of incentives to efficiency. To some extent the three Mediterranean countries face similar problems. For instance, institutional fragmentation in Turkey has led to considerable duplication of facilities with under use of staff and resources (European Commission 2002a). In Cyprus it is reported that outdated and inefficient management of the public health system has created opportunities for the private health sector to expand, with implications for equity (European Commission 2002b). Weakness in the mechanisms to refer patients between levels of care remains an important issue in Malta, Turkey and Cyprus. Clearly there is still quite a large potential for improving the microeconomic efficiency of health care delivery in some candidate countries so as to ensure that the limited resources available are used more effectively. A series of convergent measures are part of efforts that have already been made towards this goal, including the following: reductions in hospital capacity, strengthening of primary care, and financing reform.

In summary, candidate countries that are engaged in the twin processes of transition to a market economy and accession to the EU face a number of similar challenges related to:

- the health conditions of their populations;
- a macroeconomic environment characterized by strong fiscal pressures, competing priorities and imperatives of adjusting to a single market;
- many pressing demands for democratizing the governance of health care and designing structures that are more responsive to local needs and expectations;
- deficiencies in the organization of health care at micro-level, leading in some places to a need to reform outdated management structures and create incentives for efficiency.

Some common trends have emerged in the responses to these challenges. They include strengthening of public health capacity, creation of new health care funding bodies with varying degrees of autonomy, diversification of sources of funding (not always by design), creation of a more pluralist model of health care provision, strengthening of health care governance, and changes in methods of paying providers.

But also diversity in trajectories followed by health care systems

The identification of common challenges and evidence of similar policy responses do not mean that health care systems in candidate countries form a homogenous group or are converging towards a single model. A full analysis

must also explore the differences between them. This section focuses on the diverse historical, political and economic journeys travelled to reach the stage of accession and highlights a variety of institutional forms which have emerged in the course of the health care reforms.

First, it is apparent that the histories of the candidate countries are diverse. Even in central and eastern Europe, where there was a shared history of communist rule, the legacy from the socialist era differs between countries. The Baltic states were part of the USSR, thus, unlike the other countries that began the process of transition with the governmental machinery of independent states, they faced the need to create anew the basic state institutions. Four of the thirteen candidate countries (the Czech Republic, Slovakia, Hungary, Slovenia) were once part of the former Austro-Hungarian empire and inherited its institutional tradition of work-related social security systems. Malta and Cyprus, which were part of the British Empire until the 1960s, and remain in the British Commonwealth, have inherited the models of health care provision introduced by the British colonial administration. Following the split of Czechoslovakia, the evolution of social and economic policies in the two newly created countries has reflected distinct collective memories of the communist era. While in the Slovak lands the communist regime brought a relative affluence that had never before existed, the Czech lands experienced a relative deceleration or even deterioration in conditions that contrasted with the liberalization, political freedom and relative affluence experienced during the inter-war period (Radicová and Potucek 1997).

Geography also matters. The geographical location of the Baltic countries has created a natural orientation towards the Scandinavian states, strengthened in the case of Estonia by a shared linguistic heritage with Finland. Poland, which shares borders with Germany, has been subject to its influence in designing its social policies. In particular, the German Bismarckian health care model had been introduced in Poland prior to the Second World War, so that its reintroduction after the collapse of the communist bloc created a link with an earlier independent Poland, facilitating the role played by German policy advisers who were active in the reform process (Mihalyi 2000).

On the political level, although the candidate countries, as are the current Member States, are adhering to a model based on Europe of the regions, the organization of public services and the share of responsibilities and powers between central, regional and local authorities differ from one country to another and result in major differences in health care governance. In some countries, such as Estonia and Lithuania, municipalities with elected councils are granted exclusive competencies in regard to the governance of public services and can levy their own taxes. Other countries have developed an intermediate tier (provinces, autonomous counties, districts) with varying responsibilities and powers. Other countries still retain the bulk of powers at the centre while deconcentrating some limited responsibilities (Green 1998). Demographic and geographic factors associated with the size of different countries, their population density, and whether they are predominantly urban or rural, matter in many ways, influencing relations between citizens and public health authorities and public participation in the health care decision-making process. It is also important to recall that most countries have experienced boundary

changes more than once in the twentieth century, changes that in some cases have persisting consequences.

On the economic level, there are considerable disparities between the candidate countries and these variations are of utmost importance in understanding the levels of resources allocated to health care and the capacity to implement health care reforms. At the onset of the transition in the early 1990s, a collapse in GDP has been experienced to varying extents in all countries of CEE, resulting in cuts in expenditure on health. Poland had a short, relatively mild recession (6% drop in production over two years) whereas the Baltic countries experienced a long and deep recession (35–51% over five to six years) (World Bank 2002). In 1998, Poland, the Czech Republic, Hungary, Slovakia and Slovenia have either recovered their 1989 level of GDP or came very close to it, in contrast with the Baltic states, Romania and Bulgaria which, at the same date, had recovered less than three-quarters of the 1989 level (EBRD 1999).

Collective memory and pathways to reform are also important variables. During the decades preceding accession, Cyprus, Malta and to a lesser extent Turkey have had very close economic relations with western Europe whereas trade relations in CEE were dominated by Comecon. Some communist states, notably Hungary, and Poland (as well as Slovenia, whose position was different as part of Yugoslavia) introduced elements of market-based reforms and were exposed to western markets even before the collapse of the Soviet Union. This is reflected in a higher score on a liberalization index measured at the onset of transition in 1990 (de Melo and Gelb 1996; EBRD 2000). Poland and the countries of the former Austro-Hungarian empire (Hungary, Czech Republic, Slovakia and Slovenia), which are often considered as the fastest reformers among the post-communist countries, rank with Cyprus and Malta among the seven wealthiest candidate countries. Each had the opportunity to draw on previous market experiences to design institutional frameworks supporting economic transition. Variations also exist in the pace of market liberalization and privatization. Some countries, such as Poland and the Czech Republic, opted for a radical shock therapy resulting in rapid establishment of markets and major adjustments of most economic sectors. Other countries adopted a more gradualist approach which gave primacy to establishing the new institutions needed to support the desired changes.

Thus, the 13 candidate countries began the process of accession with different initial conditions, which go some way to explaining current variations in both economic outcomes and success in transforming the various sectors of their economies, including health care. Health systems are socio-historic constructions that reflect various historical, political and economic influences. In the light of the diverse circumstances described, it is difficult to envisage a single health care model for candidate countries or to expect a single pathway of health system transformation. While it is apparent that the transition and accession processes both give rise to a common set of challenges and imperatives that may explain some similar trends in the development of the health systems, there remain considerable differences between countries. Health care reforms are planned and implemented at national level, within the institutional framework of each country, according to the specific circumstances and value structures of each society. Both exogenous and endogenous factors are driving

health system reform in the candidate countries, leading them in diverse directions, reflected in diverse institutional forms. This diversity can be seen in several key areas of health care reform, including funding, governance and entitlements.

Collection and pooling of funds

The Semashko model, which prevailed within the former communist countries of CEE and the tax-funded model, adopted to varying extents by Malta, Cyprus and Turkey have both, in their different ways, resulted in health care systems mainly funded from the state budget. Reforms of health care funding in the candidate countries from the early 1990s were driven by the same principles of liberalization of social welfare and were intended to increase the financial resources available for health care, with a shift away from the centralized state model, and as a means of enforcing accountability of both providers and users of health care resources. To achieve these objectives two main strategies have been envisioned and are being implemented: creation of social insurance funds and increases in private financing of health expenditures. Although these common strategies might suggest convergence of funding policies, the financial and institutional arrangements for the new schemes differ in many ways.

One is the mix of sources of funding. Despite the evident shift to social insurance contributions, funding of health care in most countries still relies on a mix of sources including general taxation, social insurance contributions, voluntary insurance premiums and user charges. Analysis of the financing pattern in the candidate countries shows three distinct clusters:

In Slovakia, the Czech Republic, Hungary, Slovenia, Estonia, Romania, Poland and Lithuania, earmarked funds collected under the social insurance scheme comprise the greatest part of health spending and cover up to 95% of health expenditures. It should be noted that the first four countries of this group were formerly part of the Austro-Hungarian empire, which had adopted the Bismarck model of health insurance. Latvia and Bulgaria are moving towards a health insurance system.

In Cyprus, Malta and Turkey, general taxation provides the main source of health care funding but it amounts to less than 50% of health expenditures and the general trend until recently has been towards increasing the private share under the form of voluntary premiums or user charges. In this group of countries, out-of-pocket payments constitute the second most important source funding for health care. Three health insurance funds are operating in Turkey but have a limited scope and they provide coverage of only specific groups. Initiatives to implement a national system of social insurance in Malta and Cyprus are still in a very early phase of their development.

The second is the degree of concentration of the health insurance sector. It is too early to form a definitive assessment of the orientation of the health insurance market in the candidate countries, but it already appears that there are different trends in respect of the structure of the health insurance market (Busse 2002a). At least two clusters may be identified.

Some systems, such as those implemented in Slovakia, the Czech Republic,

Latvia, Poland and Romania, are relatively fragmented, thus reproducing a main characteristic of the German archetypal model. In the mid-1990s there were as many as 27 competing health insurance funds in the Czech Republic, 12 in Slovakia and 32 territorial sickness funds in Latvia. Their numbers have since been reduced but the principle of plurality has been safeguarded with nine health insurance funds in the Czech Republic, five in Slovakia and eight in Latvia. In Poland and Romania, regional health fund monopolies, with considerable autonomy, divide up the administrative territories, coexisting with a limited number of additional countrywide funds.

Other systems, such as those implemented in Hungary, Estonia, Lithuania, Slovenia and Bulgaria appear to reproduce a characteristic of the French health insurance model, with its trend towards a more concentrated, less fragmented health insurance market. The providers of health insurance in this group of countries are limited to single national funds. Regional funds, when they exist, are directly subordinated to the central funds.

The third is the degree to which the social insurance sector is steered. When implementing reforms of health care funding, policy-makers in the candidate countries were faced with the challenge of finding the right balance between, on the one hand, the will to create independent public institutions to manage the funds and, on the other hand, the risk that the governments might lose control of decision-making and thus of significant financial resources. In Hungary, it turned out that the extensive financial and political independence of the National Health Insurance Funds induced moral hazard, resulting in recurrent deficits which were automatically refinanced by the government at the expense of other sectors. Since 1998, the Hungarian Government reversed the situation in appropriating direct responsibility for the health insurance funds (Mihalyi and Petru 1999). A similar trend has been followed in the Czech Republic, Estonia and Turkey where the management of the health insurance funds is primarily a state responsibility. In contrast, Slovakia, Slovenia, Bulgaria and Lithuania have implemented a structure of governance in which power is shared between representatives of the government, employers and the insured. In Poland and Latvia, the governance of the health insurance funds falls under the jurisdictions of local governments (regional councils in the first case and municipalities in the other).

The fourth is the nature of risk equalization schemes or pooling systems. Where there are multiple social health insurance funds (Poland, the Czech Republic, Slovakia, Latvia, Romania), a risk equalization mechanism is needed to maintain the objective of solidarity and consequently prevent risk selection (cream skimming), reduce existing differences in the risk structure between the insurance companies and prevent fiscal insolvency of health insurance funds with adverse risk structures. The risk equalization schemes in the current candidate countries are still largely embryonic, but again it is clear that there is no uniformity in the initiatives that have been taken. In Poland and Slovakia, the overall revenue of the health insurance funds is subject to the equalization process (Mihalyi and Petru 1999; Hlavacka and Sckackova 2000). Romania and the Czech Republic use a formula that reallocates only a part of the revenue, respectively 25% and 60% (Busse 2000; Vladescu et al. 2000). In Latvia, the funds are de facto redistributed because the territorial

sickness funds remain largely funded by a tax-financed system (Karaskevica and Tragakes 2001).

Governance of health services

Beyond the broad pattern of increasing transfer of responsibilities to local levels and delegation of financing to health insurance funds, a variety of paths are being followed by the candidate countries in the process of redesigning governance structures for health care. Variations observed fall into two main categories, corresponding to two main targets of current reforms:

Governance of primary and secondary care

The process of decentralizing the governance of primary and secondary care in the candidate countries exhibits four distinctive patterns. Estonia, Lithuania and Bulgaria have adopted a model with features similar to that in Finland, creating the most advanced form of decentralization among the candidate countries. Municipalities with elected local governments are granted a high degree of political control over the organization and provision of primary and secondary care. Local self-governments decide on municipal budgets for health care and hold authority to privatize some services. Municipalities as owners are responsible for the maintenance and capital costs of their health care facilities, including local hospitals and polyclinics. General practitioners, as independent providers, contract with the sickness funds and operate in polyclinics and other ambulatory facilities owned by the municipalities and increasingly by private providers. In Bulgaria and Estonia, partial responsibility for financing was transferred to municipalities (Hinkov et al. 1999; Jesse 2000). For instance, elected municipalities in Estonia spend up to 58% of total income tax and can raise additional taxes for expenditures on local services.

Hungary and Latvia have adopted arrangements which are similar to those developed in Sweden, Norway and Denmark. Two tiers of elected local self-governments, autonomous counties at the intermediate level and municipalities at the basic level, divide up responsibilities for organization and provision of primary and secondary health services while tertiary care remains a state responsibility (Green 1998). Counties are responsible for providing secondary care in district general hospitals. Hospital personnel are mainly salaried employees accountable to the county councils through an executive structure. Municipalities are legally responsible for planning and ensuring the provision of primary care. They employ salaried health care teams or contract with independent general practitioners to provide services (Gaal et al. 1999; Karaskevica and Tragakes 2001). The ownership of the bulk of primary care facilities, polyclinics and hospitals has been transferred to local governments (counties and municipalities)

In Poland, the Czech Republic and Romania, the provincial authorities at the intermediate level dominate the planning and the provision of health services. But there is a trend towards bringing the management of some hospitals and primary care facilities under the control of a few larger municipalities. The

provincial structure is characterized by a system of dual subordination combining an Assembly indirectly elected by representatives of municipalities with an executive headed by a centrally appointed governor (Green 1998). The implication is that primary and secondary care are primarily planned and directed by the Ministry of Health through provincial health boards in which representatives of the municipalities can participate. Recent changes in the Czech Republic and Poland have confirmed a trend towards increasing influence of municipalities, with a greater role for the private sector. In Poland, the control of integrated health care organizations delivering primary care has been transferred to larger municipalities (Karski and Koronkiewicz 2000). In the Czech Republic, primary care is increasingly provided by independent general practitioners who operate private practices within health centres and polyclinics owned by municipalities (Busse 2000).

In Malta, Cyprus, Slovenia, Slovakia and Turkey, notwithstanding recent attempts to introduce a decentralized governance of health services, the balance of powers within the health care system is still tilted towards the centre. The systems in Malta, Slovenia and Cyprus are characterized by highly centralized structures (Muscat 1999; Albreht et al. 2002; European Commission 2002b). Central governments have the overall responsibility for planning, funding, administering and delivering primary and secondary care. Moreover, the small size of these countries mitigates against creating regional level health authorities. In these three countries, privatization has featured as the most favoured option for decentralization, notably in the primary care sector where there has been a move towards having independent practitioners contracted with the health funds to provide health services. In Turkey and Slovakia, the thrust for decentralization set out in the health sector reform has many features of deconcentration. The provincial health administration in Turkey and the district offices in Slovakia, which provide primary and secondary care, are primarily subordinate units of the Ministry of Health and administrative arms of the central government (Aktulay 1996; Hlavacka and Sckackova 2000).

Governance of public health

Two distinct paths in the governance of public have emerged from recent transformations of health systems in the candidate countries. National governments in seven states of CEE (Slovakia, Slovenia, Hungary, Bulgaria, Estonia, Latvia and Lithuania) as well as Cyprus and Malta have taken direct responsibility for public health services through the creation of a national agency for public and environmental health. In most cases, responsibilities are shared with deconcentrated units which operate at district level, in parallel and not as an integral part of local self-governments (Green 1998). It is expected that these national health agencies will make it possible to address more effectively important public health concerns because they have more capacity than local units to provide specific and complex services and because they often have the scope to raise extra funding for additional activities.

In three states of CEE (Czech Republic, Poland and Romania) as well as Turkey, public health responsibilities are primarily devolved to provincial governments. For the three former communist states in this group, this means that

they are still operating the inherited infrastructure of sanitary-epidemiological stations in which the combined functions of preventive public health and environmental health protection were run within a framework determined by the Ministry of Health.

Entitlements, benefits, coverage, users' choice and sharing of costs

Although governments in all the candidate countries have subscribed to the principles of solidarity and universality of care, the range of services covered, their accessibility, the scope of users' choice, the sharing of costs and the mechanisms of reimbursements vary from one country to another. In some states such as Malta, Slovenia, Slovakia and Czech Republic, the public health care system ensures coverage of all citizens and/or permanent residents whereas in Bulgaria, Hungary, Lithuania, Poland and Romania entitlement is based on contributions to the health insurance plan, creating threats to the equity of the health system (European Commission 2003). In Cyprus, the public sector restricts the free provision of health services only to government employees, families with four or more children, certain categories of chronically ill persons and individuals and households with low incomes. The higher income groups must pay user charges to access public health services (European Commission 2002b).

Defining a systematic basic benefit package remains an ongoing issue in many candidate countries and again the policies vary considerably. Slovakia exemplifies a state where health care benefits are very comprehensive with a wide range of services covered. Services such as rehabilitation, spa treatment, spectacles and most basic dental procedures are provided (European Commission 2002c). Other countries such as Latvia have shown a trend towards reducing the "Basic Care programme" which is reviewed annually (European Commission 2002d). In Cyprus and to a lesser extent in Malta, due to the small size of the health market, the production of some highly specialized services is not financially viable. Consequently, the Maltese and Cypriot Governments fund overseas treatment for conditions necessitating such highly specialized care.

As a means of controlling demand, co-payment is a common option used by all the candidate countries, but in diverse ways. While most countries restrict co-payments for basic benefits to drugs and specific services such as dental care, a few countries such as Cyprus and Estonia require co-payments even for outpatient visits. Freedom of choice for users of health services is a further issue. Users' choices in the candidate countries are restricted to varying degrees while each country is choosing among different options or combining several policy tools to foster appropriate use of services: gatekeeping function, choice restricted within a specific pool of providers or a territorial unit, rules of reimbursements, and co-payments.

Thus, on many key areas of health care reforms in the candidate countries, there is a strong case against the assumption that there is a single health policy track. Although the changes relating to health care funding, governance of health services, and organization of health care are still in process and in some

cases operating at a rapid pace, the evidence to date suggests that multiple paths are being followed by the different countries involved in the accession process.

Conclusion

The 13 candidate countries are all implementing major changes to their health systems, although these are largely independent of the process of EU accession. Many of the candidate countries face a similar set of challenges, reflecting the health of their populations and organization of their health care systems. Common problems arise from inadequate infrastructure, scarcity of resources and out-of-date management systems. Current reforms show many similar trends, including a shift towards health insurance, plurality in the provision of health services and increased devolution to lower tiers of governments. Yet the evidence reviewed in this analysis warns against the simplistic assumption that there is an ineluctable process of convergence. First the unique characteristics of the candidate countries, the diversity in their institutional histories, and the variations in their starting conditions during the process of transition mean that their institutional changes are likely to follow diverse paths. It has been shown that the candidate countries use various policy options to implement similar objectives, consistent with the distinct endogenous conditions shaping options and choices in each country. Second the accession process and the transition of the post-communist countries has occurred in a context of growing uncertainty as to which health care structure is most appropriate to deal with common challenges, also faced by western European systems, such as cost containment, control of technologies, shifting relationships between the different levels of care and the need for better management of both demand and provision. Within the EU, several competing models suggest different policy alternatives to deal with common challenges. For many of these issues, solutions are often tailored to the unique characteristics and traditions of each country.

The diversity of contexts, the emphasis on subsidiarity in European health policy, and the fragmentation of issues impacting on health care within the *acquis communautaire* mean that there is no single EU approach to health care that can be aimed at. Yet it is also true that purported EU requirements are used as a justification for actions driven by domestic agendas and, at the same time, true EU requirements have simply led to the creation of institutional facades designed to satisfy external expectations and demands while parallel institutions and practices that reflect domestic preferences persist (Verheijen 1999; Dimitrova 2002).

While further rounds of enlargement seem inevitable and because the current acceding countries will have to complete the process of integration after gaining full membership, EU accession and subsequent integration of the new members is a two-sided process, which must take into consideration the unique circumstances of each acceding country, drawing on knowledge of successful existing practices and recognizing the potential contribution of each new member to the broad spectrum of experience that already exists within the EU.

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