

# Current approaches to the European Health Policy

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## Abstract

*The purpose of this paper is to identify the key elements that define the new European health policy. We observed that the health policy actually appeared to be an enclave within the integration process. The development of health policy in the new Member States followed a common pattern. Therefore, the European health policy reflected a general desire on behalf of the members to have more clarity of the rules in this area, given the different interpretation of the rules by different Member States.*

*The Lisbon Treaty does not bring substantive changes regarding the public health policy, therefore the Member States shall keep their competence in defining the organization and financing this domain. However, the EU2020 Strategy states that “Europe faces a moment of transformation”. Therefore, the “Europeanization” of health policy could lead to the positive developments that all EU citizens are expecting.*

*Key words:* European public goods, Health Policy, Europeanization, new member states, integration, enlargement, sustainable development, European social policy, cross-border cooperation, free movement of services

## 1. The politics of the European Union Health Policy

### 1.1. Introduction

The current international system is in a complex process of restructuring. Within this framework, it is underlined the need to focus on international public goods. The European Union is concerned with providing the European public goods for its citizens in education, technology, industry, transport, health and others fields.

Good health is a state of physical, mental and social well-being, necessary to live a meaningful, pleasant and productive life. At the same time, a state of

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good health is an integral part of modern societies, a cornerstone of efficient economies, and a shared principle of European democracies. Modern economic progress has been built on good health - longer, healthier, more productive human lives. Good health is not just a quality of life, but the key to economic growth and sustainable development (Byrne, 2004).

These are the thoughts expressed by Mr. David Byrne, the first European Commissioner for health, in July 2004, while launching a reflection process to help define the future EU Health strategy, a few months after “the fifth wave” of accession. Was it a coincidence or not?

Europe matters. The questions are why, how and to what extent? The impact of European integration on the European Union countries and the way they adjust to Europe continue to raise challenging issues on all, whether “old” or “new”, member states. In the European Union, health policy was something like a secret garden to which few were admitted (Greer, 2009).

Public policies seem marginalized in European integration politics. Health policy actually appeared to be an *enclave* within the integration process and, consequently, one of the last retreats of national policy competence. Still, it is one of the best examples for exploring the European integration process, for demonstrating how EU and its institutions have successfully transformed a non-topic in one of the Community’s most important future policy fields. The core areas of health systems, as well as health regulation have inevitably become subject to an irresistible process of Europeanization. The approach was foreseeable, given the strong institutional self-interests of the European Commission, keen on enhancing its scope of action, persuasive in claiming the transfer of new competences to the supra-national level, while strategically raising citizens’ expectations for the development of the social European model.

There are several explanations for denying the existence of an EU health policy (Lamping, 2005):

1. *First, there is no Union legal competence for it.* National governments have, jealously and successfully, tried, and are still trying, to prevent the transfer of substantial health policy competences to the EU level. Although health protection is a Community objective and cooperation and coordination among member states are specific tasks, explicitly stipulated in the Treaties, there is also a legal tranquilizer in Art. 168 (Public Health) of the Lisbon Treaty (former art.152) – “*Community action in the field of public health shall fully respect the responsibilities of the Member states for the organization and delivery of health services and medical care*”.
2. *Second, even though Social Europe is continually taking shape, its contours remain confusing and bewildering.* Efforts to adopt European rules on this matter have to overpass substantial obstacles, all leading to the impossibility of the EU to assume the functions of the welfare state.

The examples are numerous: strong and legitimate national self-interests, the institutional, structural, organizational diversity and complexity of member states, the embeddedness of social policy in historical, cultural and economic contexts, which all serve as major sources of legitimacy, support and popularity of governments, while admitting “Brussels” limited fiscal resources.

Still, the process of Europeanization is an ongoing process with different instances. The traditional perspective is to conceptualize Europeanization as a process of institution building at a supranational level, while focusing on the EU-level policy making through formal institutions, established networks, guiding norms and shared ideas. Health policy seems to be concerned very little with this perspective, since member state governments still perceive it as a genuinely national policy field and state consolidating resource. But Europeanization can also be conceptualized as “a process of change in national institutional and policy practices that can be attributed to European integration” (Goetz and Hix, 2001) and though the member states’ political actors officially still claim to have full control and responsibility over their national socio-political issues, they have realized that the integration process already has a considerable and wide-ranging impact on health systems with a supranational legislation that is more and more dominating the national legal competences and authority. These indirect pressures materialized in what is known as the *EU spill over effects on states’ health policy decision making* consisting in three processes: a positive integration – the implementation of Directives and Regulations from Brussels that enhance the common market and the free movement of capital, goods, services and people; a negative integration – Court rulings that promote the common market and an ideological convergence concerning the development of a managerial and financially disciplined model of distribution of health care resources (Minogiannis, 2003).

Indeed, every country has its distinctive health financing, provision, regulation, professional organization, government bureaucracy and politics. International comparative statistics find it difficult to capture the nuances of either formal structures or the way systems work in practice. Healthcare was considered, from the first moments of the European construction, a national matter. With various forms in different countries, financing and health care services delivery was the responsibility of each Member State. With the exception of the issues having a trans-national impact and, therefore, in need for Community coordination, the other aspects of health system organization are entirely national matters, the EU intervening only according to the principle of subsidiarity, explicitly stipulated in art.129 of the Treaty of the European Union (Maastricht, 1993) and art.152 of the Treaty of Amsterdam (now art.168 of the Lisbon Treaty).

This situation led to a paradox: on the one hand, there are the recent Treaties, which are definitive statements of the European Law, excluding health systems from any legal harmonization, and on the other hand, there are the health systems involving people (whether we speak about professionals or about patients), goods and services, all of whose freedom of movement are guaranteed by the same treaties. A number of the European Court's of Justice rulings, the crises determined by diseases with international spreading potential are forcing the reconsideration of this political attitude. Moreover, the enforcement of the European Social Model (as stated in the Lisbon Agenda) needs health systems that provide effective care to their populations, especially if we take into account the demographic developments.

## **1.2. The Development of European Union Health Policy – a Painful Birth**

The rapid progress of European integration in the area of social policy after the 1980s surprised many. Previously, it was generally believed that the welfare states of Western Europe, with their different historical trajectories, would never subject themselves to regulation from a supranational body or take to the idea of convergence towards a common 'European' model. Today, direct regulation of issues clearly within the realm of social policy are not uncommon within the EU, for instance in the areas of public health, work and safety and access to health care. In addition, far-reaching efforts have been undertaken on a voluntary basis by the member states to coordinate policies within core welfare areas such as pensions, health services provision, poverty reduction and elderly care. These developments, which were thought unlikely to happen only a few years ago, suggest that national welfare states are not quite as 'immobile' as earlier believed. Maurizio Ferrera (2005) argues that we see today the emergence of a new type of social politics in Europe, characterized by a diminished importance of geographical borders and nationally confined arenas of policy-making. Increasingly, European citizens can choose which type of welfare community they want to belong to, as such communities need no longer be defined by territorial borders. By the same token, policymaking processes are moving from the nation states towards the European networks and decision-making bodies.

One of the driving forces behind integration in the social policy field in recent years is undoubtedly what might be called spill-over effects from the creation of the single European market in the early 1990s. As the market came into force, observers pointed to its potential threat to the social protection systems of the member states and demanded that it be amended by measures to safeguard the systems. As a result, the project 'Social Europe' was born; a discursive platform where pro-welfare forces including politicians both to the left and right, EU civil servants, unions, lobby groups and policy experts could gather to formulate an agenda oriented towards protecting the existing welfare

systems in the region and to identify common goals for these. Such efforts were, however, hampered by the fact that the member states remained unwilling to delegate authority to the EU in the area of social policy. For this reason, the goals formulated under the banner of Social Europe remained vague and non-committal and few concrete measures were taken to create social regulation that could balance the pro-market orientation of the EU Treaty. Exceptions include work and safety standards in the labour market, which have been regulated through a string of binding directives during the 1980s and 1990s, and precautions taken in the wake of the bovine spongiform encephalopathy (mad cow disease) outbreak to ensure the safe transport of blood and donor organs (Magnussen, 2009).

In the late 1990s, social policy formation within the EU entered a new phase. The activities of the ECJ drew more political attention as the court started to deliver decisions that seemed to infringe on the autonomy of the member states in this highly sensitive political area. This was true particularly in health care, but rulings with the same orientation were also handed down in other welfare areas such as social insurance. The ECJ based its decisions not on the EU social regulations, but on the articles in the EU Treaties safeguarding the four freedoms that underpinned the single market. The ECJ argued that, in order to move around freely in the region to seek work, all European citizens must have access to national social security systems on the same conditions as the inhabitants. The long-standing principles of social rights as attributes of *national* citizenship and territorial borders were put aside (Hervey, 2004).

Another important feature of contemporary European health policy is that a growing share is formulated on the basis of voluntary agreements between the member states, reached within the framework of the so-called 'open method of coordination' (OMC). The OMC refers to a process whereby common policy guidelines are formulated and translated into national policy objectives through agreements between the Commission and the member state in question. The subsequent process of implementing the objectives is driven forward by periodic monitoring, evaluation and peer review, based on agreed-upon indicators and benchmarks that compare the performance of the members or have been identified as 'best practice' in a given policy area (Borras and Jacobson, 2004). The European Council and the Ministers of Health, who see a potential for deepened cooperation among the member states in the area of health, have actively supported the process. The Commission, too, has argued that the process is desirable in order to meet common health challenges among the member states, such as ageing and medical technology developments as well as the possibility of increased cross-border patient mobility. It has also identified three basic objectives for the OMC process in health care (endorsed by the member states during the meeting of the European Council in Barcelona in 2002):

1. to ensure access to health care for all within each member state, regardless of income or social status;
2. to promote high quality of all health services provided in all regions;
3. to ensure the financial sustainability of national health care systems.

The adoption of the OMC process in the area of health care could also be seen as reflecting the broader tendency to shift from traditional, hierarchical governing techniques to more network-based and informal modes of governance in European politics (Rhodes, 1997).

### **1.3. Recent Developments**

The initial most visible institutional and governmental response at the EU level came in the Health Council of 26 June 2002 when health ministers and representatives of civil society were invited to take part in a “high-level process of reflection” on health developments in the EU. Furthermore, Commissioner David Byrne launched his own electronic Reflection Process “Enabling a good health for all” in July 2004. The Byrne Reflection Process was guided by a strategy paper strongly articulating the Commissioner’s vision for a new EU action in health, with a strong emphasis on mainstreaming health into all EU policies, on multi-level participation and on an explicit linkage of health and economic growth. *It was for the first time when health was brought into the Lisbon agenda and related processes.*

*The first Programme of Community action in the field of public health* including a precise schedule covering first the period 2001-2006 and then, in a renewed plan, that of 2003-2008, replaced the previous (eight) fragmented European Health Action Programmes which were adopted within the 1993 framework and put into place in the wake of the Maastricht Treaty. The new 2003-2008 strategy explicitly seeks to work towards co-ordination among Member States and to integrate public health-related issues into a more coherent supra-national framework. The proposed strategy had three main strands: improving information and knowledge; responding rapidly to health threats; and addressing health determinants. A high priority was enhancing data collection and health reporting across Europe, the strategy envisaging visible improvements in arrangements for managing cross-border outbreaks of infectious diseases (Mossialos, 2000).

Outbreaks of communicable diseases like AIDS, Creutzfeldt-Jakob Disease, SARS and especially BSE (Bovine spongiform encephalopathy) and potential threats to public health on a large scale, opened up temporary windows of opportunity and gave the Commission the chance to actively organize co-operation among Member States. This has been illustrated since 1999 with the organization of the Communicable Diseases Network that effectively institutionalized the surveillance and control of communicable diseases and

other policy initiatives at the EU level. In particular, it created a new European agency, the European Centre for Disease Prevention and Control (ECDC), which started working in 2005.

Acknowledging the fact that health and well-being are shared values across almost all societal sectors, in 2006, the Finnish Presidency of the EU Council launched a new strategy “Health in all policies”. Effective and systematic action for the improvement of population health, using genuinely all available measures in all policy fields, was an opening for a new phase of public health.

In October 2007, the European Commission launched the *white paper “Together for Health: A Strategic Approach for the EU in 2008-2013*, a strategy that brings together all former approaches in a comprehensive document that served as a basis for the Second Programme of Community Action in the field of public health. The European Commission's important role in health policy has been reaffirmed in the Lisbon Treaty, thus reinforcing the political importance of health. Work on health at the Community level adds value to Member States' actions, particularly in the area of prevention of illness, including work on food safety and nutrition, the safety of medical products, tackling smoking, legislation on blood, tissues and cells, and organs, water and air quality, and the launch of a number of health-related agencies. However, there are several growing challenges to the health of the population which require an efficient strategic approach:

1. First, demographic changes including population ageing are changing disease patterns and are putting pressure on the sustainability of EU health systems. The issues regarding this aspect link closely to the Commission's overall strategic objective of *Solidarity* (since this is a population segment that consumes most and contributes least);
2. Second, pandemics, major physical and biological incidents and bioterrorism pose potential major threats to health. Climate change is causing new communicable disease patterns. It is a core part of the Community's role in health to coordinate and respond rapidly to health threats globally and to enhance the EC's and third countries' capacities to do so. This relates to the Commission's overall strategic objective of *Security*;
3. Third, recent years have seen a great evolution in healthcare systems in part as a result of the rapid development of new technologies that are revolutionising the way we promote health and predict, prevent and treat illness. These include information and communication technologies (ICT), innovation in genomics, biotechnology and nanotechnology. This links to the Commission's overall strategic objective of *Prosperity*, ensuring a competitive and sustainable future for Europe, as envisaged by the Lisbon Agenda.

The document sets four core principles underpinning three strategic objectives as a focus of attention for the coming years:

- *Principle 1: A Strategy Based on Shared Health Values*

In June 2006 the Council adopted a statement on common values and principles in the EU healthcare systems, listing the overarching values of universality, access to good quality care, equity and solidarity. One of the core values is *citizens' empowerment*, healthcare becoming increasingly patient-centred, with the patient becoming an active subject rather than a mere object of healthcare. Another core issue is reducing inequities in health, given the fact that major differences in health status exist within and among member states, especially in the enlarged EU. Finally, health policy must be based on the best scientific evidence derived from sound data and information, and relevant research.

- *Principle 2: Health is the Greatest Wealth*

In 2005, Healthy Life Years (HLY) was included as a Lisbon Structural Indicator; to underline that the population's life expectancy in *good health* – not just length of life – is a key factor for economic growth. Spending on health is not just a cost; it is an investment. Health expenditure can be seen as an economic burden, but the real cost to society are the direct and indirect costs linked to ill-health as well as a lack of sufficient investment in relevant health areas.

- *Principle 3: Health in All Policies (HIAP)*

Developing synergies with other Community policies like environment policy, tobacco taxation, regulation of pharmaceuticals and food products, animal health, health research and innovation, coordination of social security schemes, health and safety at work, ICT, radiation protection is crucial for a strong Community health policy, and many sectors will be cooperating to fulfil the aims and actions of such strategy.

- *Principle 4: Strengthening the EU's Voice in Global Health*

In our globalised world it is hard to separate national or EU-wide actions from global policy, as global health issues have an impact on internal Community health policy and vice versa. Efforts are needed to ensure the attaining of global health goals, to consider health as an important element in the fight against poverty, to respond to health threats in third countries, and to encourage implementation of international health agreements such as the World Health Organisation's (WHO) Framework Convention on Tobacco Control (FCTC) and International Health Regulations (IHR).

In order to meet the major challenges facing health in the EU, the strategy identifies three objectives as key areas for the coming years:

- *Objective 1: fostering good health in an ageing Europe* – changes, resulting from low birth rates and increasing longevity, are likely to raise

demand for healthcare while also decreasing the working population, a fact that will lead to an increase of GDP spending for health.

- *Objective 2: protecting citizens from health threats* – combating pandemics or biological incidents and addressing the threat of bioterrorism requires Community-level cooperation and coordination between Member States and international actors. Action is also needed on emerging health threats such as those linked to climate change, and to patient safety.

- *Objective 3: supporting dynamic health systems and new technologies* – EU Health systems are under mounting pressure to respond the challenges of population ageing, citizens' rising expectations, migration, and mobility of patients and health professionals. To boost investment in health systems, health has been integrated into instruments aimed at enhancing EU growth, employment and innovation including the Lisbon strategy, the 7<sup>th</sup> Framework Programme for Research including the Joint Technology Initiative on Innovative Medicines, the Competitiveness and Innovation Programme and Regional Policy.

In 2008, the creation of a common European health policy took a further decisive step, as the Commission presented a proposal for a directive on patient mobility within the EU (in 2006, health services were drawn out of the Bolkenstein directive). The proposal reflected a general desire by the members to have more clarity of the rules in this area, given the apparent risk that the rulings by the ECJ would be interpreted differently by different member states. Its purpose in enhancing the EU's role as regulator and knowledge centre in the health care sector in the future; a development which implies a movement towards increased policy coordination and systems convergence in this area. Market-building policies emphasize liberalization and are generally regulatory, reflecting the 'Community method' with a leading role for the European institutions<sup>1</sup>. If the Directive "ever be adopted", it will be a definitive "victory" of market forces in the social field.

## **2. Health policy in the new member states**

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 had brought the EU to a turning point as it faced its fifth and greatest enlargement ever in terms of scope and diversity. The

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<sup>1</sup> The "Community method" refers to the institutional operating mode for the first pillar of the European Union and follows an integrationist logic having as key features: the right of initiative for the European Commission; qualified majority voting is generally employed in the Council of Ministers; the European Parliament has a significant role reading and co-legislating with the Council; the European Court of Justice ensures the uniform interpretation and application of Community law.

accession of twelve new Member States (Poland, Hungary, the Czech Republic, Slovakia, Estonia, Latvia, Lithuania, Slovenia, Malta, Cyprus, in 2004 and Bulgaria and Romania, in 2007) have created a substantial increase in the EU's 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 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 CEE 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 the EU law, amounting to about 100 000 pages of legal text organized in 31 Chapters.

The development of health policy in the Central Eastern European new member states followed somehow a common pattern. All these countries were in a process of major transition from centrally planned, socialist economies to market functioning economies. The 10 candidate countries were all implementing major changes to their health systems, although these were largely independent of the process of EU accession. However, the context of transition differed fundamentally from one country to another. First, there were national differences regarding their development, with some having a better economic performance than others. Then, each country differed in its openness to the rest of the world, with countries having very little if any possibilities to travel abroad or get information from beyond national borders. Their openness in internal debate was also quite different. Second, the nature of transition that took place at the end of 1989 varied, ranging from peaceful takeover of the political power to violent movements. The transition was also shaped by the initiation of the accession process.

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. Stabilization, liberalization and privatization of the means of production are promoted, all on a "one way" track. From this perspective, the different components of preparation for accession (technical assistance from the 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 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. The disadvantage of joining something late is that one has to accept all the decisions which were already-made by those who got there first (McKee, 2005).

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 underlines the importance of path dependence, ways in which cultural norms and inherited institutions, combined with new ones, lead to hybrid institutional and organizational forms specific to each country. Because the EU new member states differed 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. Applying the hypothesis of institutional diversity to the analysis of health care systems in the CEE countries leads to the conclusion that a universal model of health care compatible with the market economy could replace the former arrangements is simply unrealistic.

Taken together, these two perspectives draw a framework for further analysis of the evolution of health care systems in the new member states. The hypothesis of convergence offers a useful explanation for the similar challenges and pressures faced by health policy-makers in these countries that 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 within the EU, the political importance of membership and the EU's determination to ensure compliance with the *acquis communautaire* prior to their entry make a strong case for a commonality 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.

Common challenges and trends shared by the CEE countries relate to the health context, the macroeconomic context, the political organization of the health system, and the micro-efficiency of the health services (McKee, 2004). The burden of disease in these countries is substantially higher than in the existing Member States, whether we speak about chronic conditions or acute ones. Financing of health systems has become one of the most critical challenges facing governments across Europe, but in many of the new member states these pressures have become even more acute, as a consequence of a series of factors - the under-capitalization of health care infrastructure, 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 of these countries.

These countries, engaged in the twin processes of transition to a market economy and accession to the EU, faced a number of similar challenges related to:

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

Some common trends have emerged in the responses to these challenges. They include the strengthening of public health capacity, the creation of new health care funding bodies with varying degrees of autonomy, the diversification of sources of funding creation of a more pluralist model of health care provision, the strengthening of health care governance, and changes in methods of paying providers. All of these countries adopted the social health insurance system for financing healthcare. These ten countries are seeking to identify and use the right policy tools to expand health insurance coverage, contain costs, and improve the quality of services provided. *These policy tools include: the definition of a universal minimum benefit package; increasing competition among providers to increase quality and efficiency; creation of technology assessment agencies to produce evidence for coverage and investment decisions; and the introduction of private insurance to supplement public coverage.* Other priority areas for the insurance reform include the improvement of health information technology; and the use of co-payments to rationalize service use, increasing revenues for providers and diminishing informal payments.

Universal coverage is written into the constitution in a number of countries in the region, but resources are limited and real universal coverage is not yet a reality. Private health insurance in the region (where it was developed) has thus far been of the supplementary type, rather than the comprehensive “substitutive” type, where patients are permitted to opt out of the system.

On the other hand, 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 the new member states or to expect a single pathway of their 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 a 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 new member states, 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.

The European Commission has identified some key issues that deserve a particular attention in the attempt to develop efficient health policies at a national level in the CEE countries:

- the lack of clear, modern public health policies and the relatively low priority given to this sector;
- the increasing level of communicable diseases, and the decline in vaccination coverage;
- the increase in drug use;
- the need for better emergency facilities;
- the low social and economic status of health professionals and the consequent potential pressures on migration;
- the relative lack of appropriate and sufficient involvement of the civil society in health issues and the paucity of relevant institutions and associations;
- the continued negative impact on health of poor environmental conditions.

In order to overcome the above-mentioned limits, the following options could be considered:

- improvement of participation in each Community public health programme;
- improvement of the know-how and facilities related to surveillance of communicable diseases and participation in the Community network on disease surveillance and control;
- identify priorities for cooperation and exchange information;
- establish priorities related to resource allocation and investment allocations;
- promote participation of experts from the new member states in the Commission expert groups;
- facilitate cross border co-operation;
- develop health research and the use of information systems and technologies related to healthcare.

Briefly, on an overview of healthcare and policy landscape, the CEE countries have experienced significant changes over the past 15 years:

1. Population growth is static or negative, with an increase in the “greying” population, leading to *higher levels of chronic conditions* such as cancers, cardio-vascular diseases and diabetes mellitus. However, some countries in the region – notably Bulgaria and Romania – still face a relatively

high burden of infectious diseases, as well as high levels of infant and child mortality.

2. Life expectancy improved steadily, especially because of the implementation of health programmes addressing health determinants and *promoting healthy lifestyles* (e.g. by the year 2000, there was a gap of 12 years in life expectancy between the CEE countries and Western Europe. In Estonia, Latvia, Lithuania, and Romania life expectancy declined between 1985 and 1995 as living standards worsened. However, in most of the countries of Eastern and Central Europe, health status as measured by life expectancy at birth has rebounded and is again increasing. Hungary's life expectancy increased from 69.8 years in 1995 to 76.6 years in 2005; Estonia's climbed from 67.8 to 71.6 years in the same time period, and Romania saw an increase in life expectancy from 69.5 to 73.2 years).

3. The process of *decentralizing the governance* of primary and secondary care exhibits distinctive patterns, from advanced forms in which municipalities with elected local governments are granted a high degree of political control over the organization and provision of primary and secondary care to forms in which the provincial authorities at the intermediate level dominate the planning and the provision of health services. Romania purposed a strategy for decentralizing hospital care to local authorities, but the process is extremely slow and the willingness and possibilities of local authorities to take over seem to be very limited. The governance of health services rests oriented towards the centre.

4. Targeting and priority setting for national health plans is, at least theoretically, a practice for the majority of the new member states. Romania has developed national health programmes starting with 1999. The funding of these programmes comes from the state budget and, for chronic diseases, from the National Insurance Fund. Since 2007, rare diseases were introduced in national health programmes, Romania being listed by the European Commission among the member states very close to developing a national plan for rare diseases, as agreed by the Council of Ministers last summer.

5. The *number of hospital beds per capita* remains high (except for Latvia, Slovenia and Estonia). Romania has over 400 hospitals on its territory, many of them lacking specialized human resources or appropriate infrastructure. The Ministry of Health began an action for reducing the number of hospital beds by merging some of them in order to add their competence and to transfer some of them to local authorities. The process is at its beginnings and it faces resistance from local authorities (as mentioned above) and healthcare personnel.

6. Primary care is not yet sufficiently developed and specialized medicine remains oversized. In Romania, for example, many of the cases that are addressing secondary and tertiary care can be solved at the family doctor's office. This creates huge costs of hospital care that will stay the same as long as

most of the family doctors' income comes as per capita payment and not for medical services.

7. There is insufficient emphasis on prevention and an almost total absence of self responsibility for health. In Romania a comprehensive screening programme for cervix cancer was supposed to begin last year, but due to the shortage in financing (because of the financial crisis) and difficulties in establishing competences it remained at the project stage.

8. The *governance of public health* shows two patterns: in some states national governments\* have taken direct responsibility for public health services through the creation of a national agency for public and environmental health that shares responsibilities with deconcentrated units operating at the district level, in parallel and not as an integral part of local self-governments. These national health agencies are able to address important public health concerns more effectively because they have more capacity than local units to provide specific and complex services. In other states of CEE, public health responsibilities are primarily devolved to provincial governments, still operating through an infrastructure determined by the Ministry of Health. Romania established, in December 2009, a new National Institute of Public Health, formed of the former Regional Institutes of Public Health. The Institute is supposed to coordinate, provide expertise and backup the public health activities from the district level through 6 regional centres for public health.

9. Most CEE countries have adopted *social health insurance* models, but this financing structure proved to be insufficient in adequately sustaining national healthcare budgets, with many countries experiencing a significant healthcare deficit (e.g. Hungary) and the development of an informal healthcare economy.

10. Overall levels of spending on health care in the ten countries – measured both in absolute terms and as a percentage of Gross Domestic Product (GDP) – fall below, and in most cases considerably below, spending levels for the fifteen pre-2004 members of the EU (e.g. in 2004, total health spending ranged from \$508 per capita (measured in PPP) in Romania to more than \$1,300 per person in the Czech Republic, Slovenia, and Hungary. In 2004, the average level of per-capita health expenditures for the 15 core members of the EU was \$2,510) (Waters, 2008).

11. Governments are under increasing pressure to better support a rational and transparent spending decisions. Despite deficits and insufficient budgets, healthcare spending has increased in the region due to several factors: a high demand for health services spurred by increases in population expectations, improvements in medical technology and the availability of new products. Additionally, health care infrastructure will need to be replaced. Pressures to

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\* Slovakia, Slovenia, Hungary, Bulgaria, Estonia, Latvia and Lithuania.

raise health worker salaries will sharpen as health professionals increasingly cross national borders. As populations age, countries in the region will have to face a much higher “dependency burden” – and, with larger shares of older populations, health care costs will grow significantly and health insurance systems will be stretched. As a result, countries throughout the region will need to identify *additional resources for insurance systems* including income taxes, increased payroll taxes, official co-payments, and private health insurance. There is a strong potential role for private health insurance in the region – in terms of increasing financing, taking pressure off of the public insurance system, promoting innovation in financing and delivery, and creating incentives for quality and efficiency in the provision of care. The form of private insurance takes will depend on the services provided by the government and the regulatory environment created by each country and by the European Union. Substitutive insurance – allowing individuals to opt out of social health insurance would expose social health funds to potential adverse selection if private insurers successfully capture the wealthiest and healthiest individuals. Supplementary insurance – as in the UK, France and Spain – covers benefits and procedures not covered by the statutory insurance, and can reimburse for out-of-pocket expenditures for statutory benefits\*.

12. In countries where private health insurance is absent, social health insurance systems should clearly *define benefits package* – so that patients understand what they are entitled to, and insurers know where they can cover supplementary services – and ensure that physicians have the resources to provide those services. There are several important potential barriers to further defining benefits packages; including resistance among patients, providers and politicians – due to the need to explicitly exclude some services and, in several countries, a lack of reliable data on current service utilization patterns and the true costs of providing services.

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\* There is a strong potential role for private health insurance in the region – in terms of increasing financing, taking pressure off of the public insurance system, promoting innovation in financing and delivery, and creating incentives for quality and efficiency in the provision of care. Private insurance can also be a source of financing for rebuilding infrastructure in the region. Currently, there are significant barriers to the growth of private health insurance. These barriers include the *lack of a defined benefits package in social health insurance systems*, public perceptions that governments should provide health services, limited population purchasing power, and the persistence of informal payments.

In Slovakia, where copayments were introduced in 2003, private insurance to cover those payments is becoming more common. In Bulgaria, where the share of the population with private health insurance has grown to an estimated 12 percent, insurance premiums (below a cap) are not subject to corporate income tax, providing an incentive to employers to purchase insurance for employees.

13. Several CEE countries introduced various forms of *cost-sharing* with the aim to support the following objectives: cost containment through moderation of service use; revenue raising; formalizing informal payments and making individuals responsible for their health. Romania will implement co-payment mechanisms starting this year (they were proposed for July 2009, then postponed for September, and now they are facing the same resilience from the civil society).

14. There is significant variation across the central and eastern European region in the *prominence of the private sector in the delivery of health care*. Throughout the region, most primary care practices and increasing shares of outpatient specialist practices are privately owned. The majority of these providers contract with health insurance funds and are therefore partly paid with public funds. Competitive and selective contracting of health care providers by insurance funds is one method of promoting competition among providers. In Romania, one of the best practices in this field is privatization of renal dialysis units.

15. 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 the CEE member states. A first set of issues is raised by the opportunities offered to the health sectors by elimination of barriers to free movement of goods. Pharmaceutical spending grew steadily in the CEE countries due to several factors: a lack of regulatory mechanisms, rising pharmaceutical prices and a mounting demand for new drugs. In order to manage costs, many new member states have introduced a number of reimbursement and pricing controls such as the reference pricing system. New technologies were implemented with little or no regard for costs and effectiveness. Health technology assessment (HTA) is a key mechanism to ensure value for money. Among the new member states national HTA and pharmaceutical - economic guidelines have been implemented in Hungary, Poland and the Baltic States<sup>1</sup>.

16. A second set of issues is raised by the rules on free movement of professionals within the European single market. For the new member states, being part of the European Union means the axing of borders and therefore free movement of people within the bloc, as well as recognition (according to Directive 2005/36/EC) of qualifications and training obtained in their own country. In short, that makes migration easier and, with average wages significantly lower in most of the 10 new member states, much more likely. It is a situation well documented in Romania, where, if the process is not stopped and

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<sup>1</sup> Corinna Sorenson, Panos Kanavos, Manolis Karamalis (2009), HTA in Central and Eastern Europe: Current Status, Challenges and Opportunities, in *Journal of Medical device Regulation*, 6(1): 34-45.

reversed, in few years not only small towns' hospitals will lack specialists, but even bigger hospitals from less developed areas.

17. A third set of issues is raised by the free movement of patients, especially since the judgements by the European Court of Justice that 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 CEE 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. Romania was among the five states that blocked the adoption of the political agreement on the Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare in December 2009. The core issue that led to this decision is the lack of the condition that reimbursement for medical services should pursue the same conditions as in the member state of affiliation, namely reimbursement would be possible only in situations where healthcare providers have a contract with a statutory social security system. In Romania's view this will ensure the respect for the principles of non-discrimination and equal treatment of "domestic" patients.

### **3. Conclusions**

European national policy-makers broadly agree on the core objectives that their health care systems should pursue. The list is strikingly straightforward: universal access for all citizens, effective care for better health outcomes, efficient use of resources, high-quality services and responsiveness to patient concerns. It is a formula that resonates across the political spectrum and which, in various, sometimes inventive configurations, has played a role in European national election campaigns. Yet, this clear consensus can only be observed at the abstract policy level. Once decision-makers seek to translate their objectives into the nuts and bolts of health system organization, common principles rapidly devolve into divergent, occasionally contradictory, approaches. Perhaps the biggest obstacle in implementing reforms has been the absence of effective stewardship by governments. Too often, policy makers have lacked an overall perspective of health systems, focusing their efforts on only partial initiatives. Nor have they exercised effective leadership or established appropriate regulatory infrastructures. In addition, limited technical capacity and lack of appropriate information systems have hindered the introduction of often very complex reforms (Figueras, 2005). This is, of course, not a new phenomenon in the health sector. Different nations, with different histories, cultures and political experiences, have long since constructed quite different institutional arrangements for funding and delivering health care services. The diversity of health system configurations that has developed in response to broadly common

objectives leads quite naturally to questions about the advantages and disadvantages inherent in different arrangements, and which approach is ‘better’ or even ‘best’, given a particular context and set of policy priorities.

The diversity of contexts, the emphasis on subsidiarity in European health policy (Puşcaş, 2007), and the fragmentation of issues impacting on health care within the *acquis communautaire* mean that there is no single EU approach to health care. Unfortunately, in many cases, 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 façades designed to satisfy external expectations and demands, while parallel institutions and practices that reflect domestic preferences persist.

A second observation is that health care and health system reforms and the change in health policies in the Central Eastern European countries was a consequence of transition, rather than the effect of accession and began before the start of negotiations with the EU. The process of EU integration is raising pressures on health systems to adapt to their situation as member states. Some are performing actively and seem more implicated

Although governments in all the new member states 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. Defining a systematic basic benefit package remains an ongoing issue in many of these countries and, again, the policies vary considerably. As a means of controlling demand, co-payment is a common option used by many of the new member states, but in diverse ways (Waters, 2008).

Thus, on many key areas of health care reforms in the CEE countries, there is a strong case against the assumption that there is a single health policy approach. 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 integration process.

These concerns have intensified over the last decade as policy-makers have sought to improve health system performance through what has become a European-wide wave of health system reforms (Busse, 2002). The search for comparative advantage has triggered – in health policy as in clinical medicine – increased attention to its knowledge base, and to the possibility of overcoming at least part of the existing institutional divergence through more evidence-based health policy-making.

On December 1<sup>st</sup> 2009, the Lisbon Treaty was legally empowered. The institutional arrangements and the definition of community and national competences did not bring substantial novelty in what concerns health policy in the EU. This means that public health policies remain among the fundamental

objectives of EU action, but member states keep their national “powers” in organizing, financing and delivering health care. There is, though, a wording innovation that broadens EU’s attention in this matter: art.2, par.1 states “The Union’s aim is to promote peace, its values and the *well-being* of its peoples”. The use of the term well-being is not necessarily a change, but rather a return to the origins of the European Community because the Treaty constituting the European Coal and Steel Community, stated that the scope of the legal act was to “*promote the improvement of the living and working conditions of the labour force* in each of the industries under its jurisdiction so as to make possible the equalization of such conditions in an upward direction” (art.3, par.e). It is also remarkable that the same term is used in the World Health Organization’s definition of health “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”\* (Pușcaș, 2010).

A tendency for the orientation of the EU towards citizens becomes more and more visible, as prescribed during the negotiations of the 2003-2004 Intergovernmental Conference on “The Convention on the Future of Europe” and as promised by EU leaders following the French and Dutch “NO” to the ratification of the Constitutional Treaty. Since the interpretation assigned to the above mentioned legal wording innovation has not been argued against, we can conclude that the EU is more and more interested in health policies.

The recent presentation (March 3<sup>rd</sup> 2010) of the “EUROPE 2020: A European Strategy for smart, sustainable and inclusive growth”, gave the president of the European Commission the opportunity to ascertain that we live a time of economic interdependence, clearly demonstrated by the global impact of the economic crisis. Mr. Barosso considers that the answer the EU has to give is a better political coherence and stronger economic governance. French MEP Pervenche Berès notes that wrongly focusing on exit strategies in terms of fiscal consolidation, the strategy focuses very little on the fight against poverty and social exclusion – notionally a key priority for the EU in 2010. The president of the Social Platform of European NGOs, states that this is a “crisis approach”, and the EU2020 Agenda should have focused more upon what is necessary during the post-crisis period, namely “commitment to reinforce universal protection systems and policies, to give all people in the EU quality jobs and a decent quality of life”. Let’s remember that the 2007-2009 Eurobarometers proved that the citizens’ expectation from the EU was, first, social progress that was no longer only GDP amount, but also factors contributing to the “quality of life”: income, jobs, health, education, safe environment. That is why today we

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\* Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

face a lot of interdependences in the society, social aspects needing to be added to political and economic ones. We have to admit that, under the pressures of globalization, ageing, development of services, the EU had to move towards social policies able to build a “Social Europe”

EU2020 wants to offer a “vision of Europe social market’s economy for the 21<sup>st</sup> Century”. Defining practical objectives and targets (employment, education, poverty reduction, etc.), EU2020 lacks references to health policies. It is the political actors’ role to understand that as long as “health is wealth”, social policies and internal market presume “good” health. Although several member states required that the EU2020 pay more attention to social outcomes, including health policies, the Commission did not insert the relationship between accessibility, improvement and financing recommended by the EU Health strategy.

Since the beginnings of the ‘90s, the concept of European citizenship was debated, and was recently introduced in the Lisbon Treaty. The perception of the EU citizens on this concept will be determined by a process development and it will be shaped by the outcomes of this process. The open debate on the draft of the Constitutional Treaty revealed more practical elements the EU citizens envisaged for European Citizenship, health policy issues being among them “there can be no Europe without a Europe of health”. “The Alternative Report on European Citizenship”<sup>2</sup> defines European citizenship in terms of common solutions to trans-national issues such as combating climate change or major health scourges and promoting cross-border social rights.

DG SANCO<sup>3</sup>, in its “Future Challenges Paper: 2009-2014” states that “improving the health and well-being of the European citizens is important for the EU” and argues its position by a strategic approach:

1. Identify core issues to protect and improve health across the EU;
2. Health in all policies;
3. Increasing effective EU action on health at a global level.

Acknowledging that “health is one of the highest values for European citizens” and taking into account the current EU competencies, the strategic approach of the EU Health Strategy and the need for further actions at the EU level with high potential added value for health, the European Union Health Policy Forum<sup>4</sup> identified the following strategic priority areas:

1. Economic change: health as an economic driver and cost;

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<sup>2</sup> European Citizens Action Service,  
[http://www.ecas-citizens.eu/index.php?option=com\\_search&searchword=titutions](http://www.ecas-citizens.eu/index.php?option=com_search&searchword=titutions).

<sup>3</sup> European Commission (2009), *Future challenges paper: 2009-2014*,  
[http://ec.europa.eu/dgs/health\\_consumer/events/future\\_challenges\\_paper.pdf](http://ec.europa.eu/dgs/health_consumer/events/future_challenges_paper.pdf).

<sup>4</sup> European Union Health Policy Forum (2009), *The EU Health Policy Forum. Strategic Priorities Including Specific Priorities for 2009-2010*, Brussels,  
[http://ec.europa.eu/health/ph\\_overview/health\\_forum/docs/ev\\_20091016\\_rd01\\_en.pdf](http://ec.europa.eu/health/ph_overview/health_forum/docs/ev_20091016_rd01_en.pdf).

2. Demographic change: its impact on health systems and health needs;
3. Environmental change: its impact on the organisation of health services and impact on health;
4. Social change and public health;
5. Technological change: innovation and development.

The EU 2020 Strategy and most of the European leaders state that “Europe faces a moment of transformation”. Coming out of the crisis needs to be a starting point not only for a new economic development for Europe, but also for developing a viable social model, based on high standards of life, including a good health, more social cohesion and stronger competitiveness. Together with these aspects, the “Europeanization” of health policy could lead to the positive developments that all EU citizens are expecting.

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