E-BRIEF
CASE - Center for Social and Economic Research

2007/6 September 2007

Health Status and Health Care Systems in Central and Eastern Europe

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In the last 18 years, the countries of the Central and Eastern European region (CEE) have experienced dynamic epidemiological developments characterized by improved average life expectancy. Despite the marked improvement in that area, most CEE countries have yet to achieve the average life expectancy of the EU-15. Significant discrepancies, even between the CEE countries themselves, remain a fact. Nevertheless, the overall health of the CEE population is improving. This, together with demographic changes such as aging, may have an impact on future medical service utilization levels and health expenditures. These demographic and epidemiological changes are taking place together with the institutional transformation of the sector.

These are some of the issues that were examined in the Ageing, Health Status and Determinants of Health Expenditure (AHEAD) project. The three year project, conducted by a network of 18 European research insitutions, examined the scale of health improvement in Bulgaria, Estonia, Hungary, Poland and Slovakia in the context of demographic changes and the transition of the health care sector. The results indicate that health status and age are the main determinants of both medical service utilization levels and health expenditures. Moreover, the researchers point out that in the face of ageing populations in the region, further changes in the health care sector, including increased financing and more efficient management, are essential.

Slow improvement in health indicators

With regard to life expectancy (LE), Poland and Slovakia are clearly getting closer to Western European levels as the LE rate is only lower than Western Europe by 4 years (Table 1). This progress is predominantly due to a decrease in mortality indicators[1]. Yet the gap between the healthy life expectancy indicator (HALE) and the LE rate in Poland and Slovakia amounts to about 12 - 14 years, whereas in the EU-15 it is only 8 years. This gap implies that the improvement in longevity in Eastern Europe has not led to an improvement in the quality of life (i.e. living without sicknesses and/or disabilities).

In Hungary, living standards are relatively advanced (when measured, e.g. by GDP per capita level). Expenditures on health care are also higher than in other countries in the region; total health expenditure amounts to 7.8% of GDP compared to 5.7% in Slovakia and 5.1% in Estonia,[2] yet health indicators lag behind those recorded by their northern neighbors. The analysis of underlying reasons remains unequivocal. Hungary experienced population ageing and entered the second phase of demographic transition as early as the late 1950s. Besides factors related to lifestyle and hazardous health behaviors, Hungary's poor health indicators might hypothetically be interpreted as a result of these earlier demographic changes.

Surprisingly poor health indicators are also observed in Estonia, a country which has had a successful transition experience in terms of implementing favorable institutional

Table 1. LE at birth and HALE

Country	Total expenditures per capita in USD	Share of health care expenditures in GDP %	Share of health insurance in total health care funding %	Share of budgetary resources (from general taxation) in health care funding	Share of personal income in health care funding
Bulgaria	214	4.7	10.0 (2000)	70.0	20.0
Estonia	559	5.5	65,6	10.7	23.7
Poland	558	6.2	57.0 (2003)	8.0	35.0
Slovakia	698	5.8	85,9	3.2	10.9
Hungary	911 (2001)	6.8	71.6 (2000)	12.2	16.2
CEE	539	5.6	n/a	n/a	n/a
EU	2323	9.0	n/a	n/a	n/a

Source: WHO 2002 and AHEAD, WP II country reports

1 infant mortality rates and death rates related to circulatory diseases and external causes
2 WHO Health For All (HFA) data 2005.

changes, a market economy and an improved standard of living. The mortality and morbidity profile in Estonia is an extreme case among the Baltics. It is more similar to the group of Commonwealth of Independent States (CIS) countries, Russia in particular, than to Central European countries. In Estonia, the transition is still accompanied by a lifestyle that is hazardous to health; tobacco and alcohol abuse, poor diet, growing drug abuse, hazardous sexual behavior and unsafe driving are common in this country. Health promotion is a challenge Estonia needs to meet, not only as a part of an improved health care system but also in terms of valuing human lives.

Bulgaria represents the southern region of Central and Eastern Europe countries and, as such, exhibits health indicators typical of countries in that region. In some cases, such as mortality due to cancer, Bulgarian indicators are better than other countries in the region. Yet many health indicators are worse when compared to other Central European countries (e.g. mortality due to cardiovascular diseases, infant mortality). Statistically, high infant mortality rates and the continuously high female mortality rates (which sharply increased in the 1990s) are the most conspicuous problems.

In all the countries included in the research, the analysis of factors correlated with health status[3] confirmed the correlation between self-assessed health status, on the one hand, and age, education, income and professional activity on the other. The self-assessed health status of individuals deteriorated considerably with age. In terms of education, economic status and professional activity, evidence from each of the countries exhibited a correlation with positive self-assessment of health status. Thus the individuals with higher levels of income and education, and those that were professionally active, were more likely to give a positive assessment of their health status.

Institutional changes in the health sector

Changes in the epidemiological profile of CEE countries have been accompanied by radical institutional changes in the health care sector and should be discussed in the context of the changing health care sector environment. Public funding principles have shifted (from general taxation towards health insurance), and the scope of medical benefits provided from public funds has gradually been reduced. Due to the high uneployment rates common in CEE countries[4], health insurance premiums are not an effective source of funding for the sector. Furthermore, premium increases would increase non-wage labor costs. From the standpoint of financing sources, health care funding tends to be mixed: a combination of budgetary and insurance funding. In all the countries the share of individual, out-of-pocket financing by the patients has been on the rise. The introduction of official co-payments for medical services in the public sector has been part of a recent wave of reform (in 2002 in Estonia and in 2004 in Slovakia).

Service providers (medical service institutions) have been privatized, almost completely in terms of primary health care (PHC), and on a large scale with regard to outpatient specialist care. The functioning of those institutions is largely subject to geographically de-centralized administrations. A national network of health care units is specified on statutory terms, with precise definition of the criteria required in order to obtain public financing. In Estonia and Poland the payer function is consolidated and re-centralized from regional sickness funds to a national insurance institution. At the same time, defining the role of regional and local self-government remains a major challenge as far as the provision of medical services for the population is concerned. In all the countries, the role of regional self-governments as autonomous units of administration has increased. However, it must be

Table 2. Health care financing sources and levels in analyzed CEE countries in 2002

Country	Total expenditures per capita in USD	Share of health care expenditures in GDP %	Share of health insurance in total health care funding %	Share of budgetary resources (from general taxation) in health care funding	Share of personal income in health care funding
Bulgaria	214	4.7	10.0 (2000)	70.0	20.0
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Source: WHO Health Care Systems in Transition for relevant countries and for Poland MZ 2004

3 This was performed by means of logit methodology on the basis of representative research from country statistical offices..

4 The overall employment rate in the 1990s decreased by at least 10 percentage points.

noted that autonomous regional self-governments do not contribute to consolidation and savings-oriented efforts in the health care sector. From an organizational standpoint, the health care sector has become rather disintegrated.

Health care funding in the countries included in the research is low. At the same time, the gap in the level of resources per inhabitant between countries is quite significant. If we relate the size of per capita spending in USD according to purchasing power parity (PPP) to the country with the lowest funding (Bulgaria), Poland will spend 3 times more on health care per inhabitant, Hungary 5 times more, and the average for the old EU countries will be 10 times higher than in Bulgaria (Table 2). Health has not been a policy priority, in spite of numerous political declarations and a social drive towards reform. According to international studies, the societies of new EU member states most frequently mention the need for reform, particularly in Hungary and Poland (Stockholm Network, 2005). Although it is not quite clear which way such a reform should go, those opinions are a natural consequence of the negative evaluations of national health care systems.

Conclusion

The health care systems in CEE countries were subject to significant changes during the transition period. These changes were made in order to adjust to the mainstream of transition. Thus health care systems in the region saw increased autonomy of institutions and professions, the development of local and regional self-government, and a greater impact of the market. These changes also included the introduction of health insurance and an increase in overall spending levels on health care. Despite the positive changes, the CEE region is currently facing serious problems with coordination, system disintegration and lack of control over the market environment (especially in the area of drugs).

In the near future, the health care systems of the CEE will face increased health needs caused by the dynamic ageing of the society and changes in epidemiological patterns. The changes will lead to an increased demand for care, especially among the elderly. Therefore, the countries must improve funding as well as implement rationing reforms (the introduction of official rationing and cost-effectiveness techniques), sector integration (a managed care approach) and the development of an information and analysis base for better governing and supervision over new technology application.

For more on the AHEAD project, please see:

CASE Studies and Analyses No. 348
Investing in Health Institutions in Transition Countries
by Stanisława Golinowska and Agnieszka Sowa.

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