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The Effect of EU Membership on the Health Care Systems of Member Countries in Central and Eastern Europe

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Summary

Health and health care provision are one of the most important topics in public policy, and often a highly debated topic in the political arena. The importance of considering European Union accession's impact on the health care sector of new member countries is highlighted by studies showing that accession to the Union has significant impacts on the socio-economic indicators of the new members, while the impacts on the health care system are less known. This is particularly important for a Central and East European country such as Croatia, where a policy responsive government indicates a high level of quality of democracy (Roberts, 2009) and where issues in the health care system have been carried over from the previous regime.

In this study, I summarize the current status of health care in the European Union and the reasons behind the failure to create a stronger legislative framework around health care issues and its consequences. I find that the absence of more meaningful hard laws has stimulated the creation of alternative soft law practices to harmonize health systems across the Union, with uncertainty about its impact on health outcomes in new member countries, including Croatia.

Keywords: Health Care, Soft Law, European Union, Croatia, Hard Law

Introduction

With the continued expansion of the European Union, the issue of health care systems and policy within the joining member countries has become more salient. The accession of new members has an impact on the Union's health care issues, both through the added diversity of a new member's health care system as well as

through the impact of EU membership on the new member's health care system. While one cannot speak of a common EU health care policy, the continued integration of the European market through multiple sectors such as agriculture, free movement of labor, and food safety, among others, has had meaningful implications for public health. Consequently, some developments have been made in addressing a handful of cross-border health care issues, such as the movement of physicians, and the compensation of patients who seek care in another EU member country, but much more is part of the debate concerning where health care in the EU is moving.

While most health care ministries within the accessing member countries form a task force to address accession issues, there are no negotiation chapters within the accession process to address health care systems in particular. In fact, health care issues are only mentioned tangentially through negotiation chapters such as consumer and health protection. Given the widely accepted significance of the implications of health on GDP growth, economic development and socio-economic equity, among others, and the disparity in health indicators between the populations of the former communist countries and those of the old EU members, why has the EU not been more proactively involved in creating a health care policy that would force health care system reform in the new Central and East European (CEE) member states?

This paper seeks to analyze the impact of EU membership on the health care systems of the new and accessing member states of CEE, as well as to determine the factors that have prevented a more direct and defined involvement of the EU in the health care sector of the new members. This is particularly important given that CEE countries face a different set of health care challenges, from greater health care disparities compared to those of older EU members, to a tradition of comprehensive state sponsored health care provision as one of the central features of the former communist social welfare state.

I find that the European Union's attitude towards health care policy is a result of the long tradition of non-involvement, or passive/reactive involvement, in arising health care matters that stem from the relegation of health care issues to the internal markets and governments of member states through its treaties and directives. While a similar attitude has been extended to new member states, there is a growing recognition that emerging problems such as movement of labor/patients, and socio-economic differences between member countries are creating the need for additional coordination or integration of health care policies and practices. An example of Croatia is illustrated, along with the implications for its accession on the health care system.

Europeanization and Health Care

While the definition of the term “Europeanization”, long at the center of an expanded academic debate, is not at the center of this study, it is worth noting that its use in the present study conforms to the definition used by Richardson to mean ‘the processes by which the key decisions about public policies are gradually transferred to the European level (or for new policy areas, emerge at the European level)’ (2012: p. 5). Thus, it is distinguished from other processes such as *EU-ization* (Radaelli, 2003), which focuses on the domestic adaptation to the EU policies, which are often mislabeled as Europeanization (Caporaso, 2007). Thus, the interest of this study is to analyze the extent to which the center of the policy making authority has been moved to the EU level in the health care policy sector.

Policy making authority at the EU level is guided by the legal framework within which it was created, i.e. Treaties, which define the full scope of European Law. In 1975 the first notable action towards health promotion was the Doctors’ Directive (Council of EU Directive, 1975), which set the basic educational standards as a standard to be applied by each country. However, the period between 1960 and 1980 was a period of “eurosclerosis” or lack of interest in further integration (McKee and Mossialos, 2006). With the signing of the 1987 Single European Act, the free movement of capital, goods and labor brought new implications for the health and health care, yet the scope of action in this regard was limited to the matters that directly rose out of the law. Until the 1992 Maastricht Treaty, health care was not even specifically mentioned within the legal EU framework, and here it was the first time that health care was explicitly stated to be the responsibility of the member states. Thus, member states have agreed that, while most other social policy areas are bound by EU rules on social security coordination, social and medical assistance should stay exempt from it and stay under the control of the internal market of member states. Some argue that because health care systems reflect national culture, institutional frameworks and political choices that have derived from them, there should not be an effort to harmonize them (McKee and Mossialos, 2006). However, the recognition that the increasing integration of the EU markets has had unpredictable consequences on health care issues, such as cross-border patient rights, the movement of medical professionals and movement of medical equipment and pharmaceuticals, has led to what some call the neofunctionalist role in the EU health policy making (Greer, 2006, 2009).

While health care has been relinquished to the member states’ competence with little or no input from the EU, other parts of EU policy have been moved to the supranational level and have resulted in what Scharpf calls ‘constitutional asymmetry’ where market promoting policies have been relegated to the EU level, while social protection and equality have remained at the national level (2002). In the absence

of European law pertaining to health care, there has been a steady and increasing involvement of the European Court of Justice (ECJ) since the 1990s into health care matters, and its rulings have forced member countries to comply with its decision at the least, while its impact is still seen as ambiguous at best (Brooks, 2012). In that capacity, the effect of the ECJ is considered a destabilization right, a legal right that undermines existing procedures of ‘entrenched’ incumbent organizations (Sabel and Simon, 2004). If applied, such a right obliges the institution to change by responding to the altered legal framework by either changing the policy to conform to the law, changing the law to eliminate risk, or attempting to influence the possessors of the destabilization right in order to neutralize it (Greer, 2012). In the case of the ECJ and health care law, the Court has passed laws, such as the right to obtain non-emergency medical care without prior authorization, where the national courts have had to respond to the creation and extension of the new European rights in deciding whether and how much to comply with the decision of the Court. That has created what Greer calls a ‘restabilization’ response by the policymakers where, in the wake of the destabilization of the existing arrangement created by invoking EU authority, the challengers and entrenched incumbents try to take advantage of this situation which results in Europeanization, since the holders of the new right are now engaged in shaping the future of EU policy making by accepting it or by limiting it (2012). Thus, the ECJ’s decisions create constitutional asymmetry because, while the EU is better at market driven liberalizing policies, the ECJ’s rulings attempt to create market correcting ones. Often times the ECJ’s decision, however, has further implications for cases by opening the proverbial can of worms: examples of such rulings involve the 1998 *Kohll and Decker* decision, which ruled that Luxembourg could not limit its reimbursements to providers within that country, a decision that evolved into the *Watts* decisions by the 2006 ruling that national health service systems were subject to patient mobility law. This direct effect of the Court is important because it leads to a degree of legal integration between the member states, which McKee and Mossialos argue will lead to political and economic integration by virtue of the cumulative effect of these specific rulings (2006). Thus, the ECJ’s decisions have created competency and outlined a policy, leading to a ‘creeping European integration’ (Greer, 2012) resulting in the creation of certain hard laws, such as the ‘Directive on the Application of Patients’ Rights in Cross Border Healthcare’, and the ‘Directive on the Recognition of Professional Qualifications’.

In addition to the hard laws, which take on a form of formal EU laws, and in the absence of a comprehensive European health care policy integration, a network of organizations has been engaged in the creation of what is known as soft laws (Greer and Vanhercke, 2010; Sabel and Zeitlin, 2010). Soft law is comprised by a series of informal agreements of cooperation, consultation and synchronization of best practices, through a voluntary process of associations in order to coordinate health care

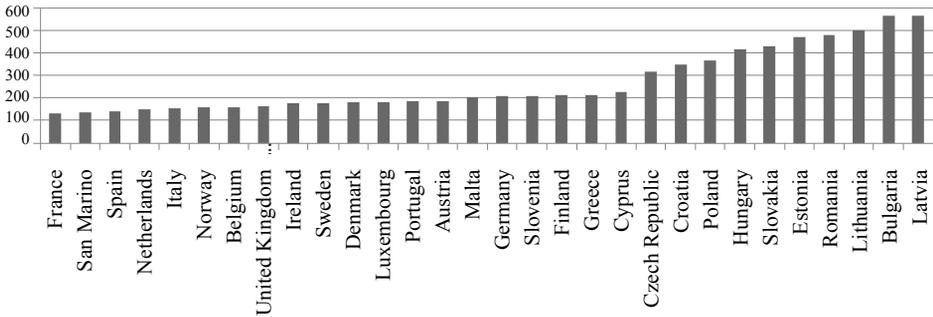
practices and improve health outcomes across the member states. While such networks and cooperative agreements do now have the force of law, they seem to have produced positive results in the area of public health through the creation of bodies such as the Open Method of Coordination (OMC), which offers legitimate official platforms for health ministers to argue about their obligations to the entrenched social goals in the OMC (Greer, 2012). Another product of these existing networks of cooperation was the creation of the European Medicines Agency (EMA), tasked to determine whether a medicine should be deemed safe for sale to treat certain conditions across the Union. Finally, the area of communicable diseases control started off through the limited EU grants for monitoring of specific diseases such as AIDS, avian flu, and others, and has resulted in the creation of permanent network of the European Center for Disease Control and Prevention.

Given these increased movements towards restructuring health care, why have regulatory reforms not happened? Greer argues that there are two reasons: first, there has not been much pressure for liberalization where the lack of a supporting coalition (such as the ones surrounding the creation of soft laws) represents a significant impediment; and second, the Court's apparent retraction from its original logic, with increased relaxation about the exceptions to the internal market rules, such as the retraction of its attempt to create a pan-European definition of medical procedure standards (2012). It is not surprising that similar coalitions to the ones formed supporting the creation of soft laws have not formed around the creation of formal, regulatory reforms to what could become a more comprehensive European health care system. First, the stakeholders surrounding the creation of hard laws involve policymakers who serve on behalf of entrenched interest who reap marginal returns from the existing internal markets. Second, health care is a sector that has historically been one where benefits from reforms have only been seen over a long run, are expensive to fund, and where it is difficult to find areas of large profits, besides the pharmaceutical and medical equipment industries. Thus, there seems to be enough resistance, and not sufficient support in coalition building around the health reform issue.

A 2006 study commissioned by the European Commission Research Directorate General suggests that the fundamental problem is that the Single European Market (SEM) has quite different goals from that of the national governments regulating the health care systems in that while the SEM requires health services to adapt to market rules in an integrating common market, governments try to adapt rules in order to ensure effective delivery of health services within the social model (Busse, Wismar and Berman, 2006).

However, the conversation about the present health care environment in the EU does not reveal much about the consequences that EU accession has had on the new

Figure 1: Male Mortality Due to Cardiovascular Disease and Diabetes per 100,000



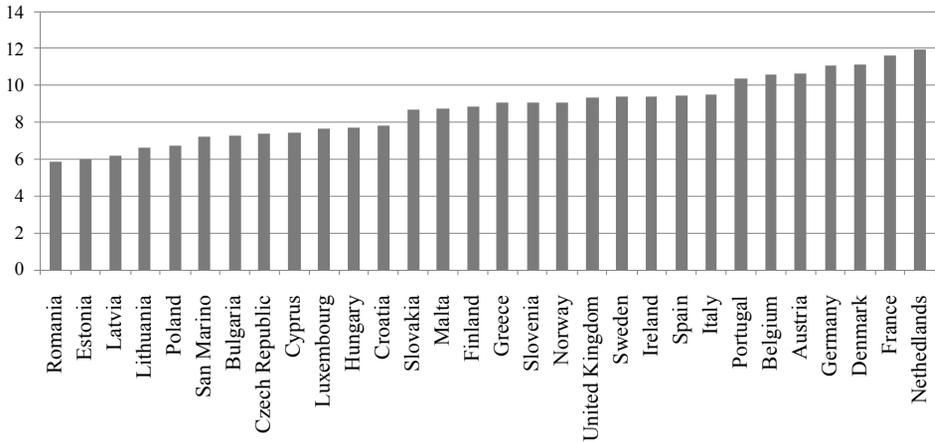
Source: World Health Organization.

members and what implications it may have on the upcoming new member country of Croatia. The next section outlines some of the health care issues facing the new member countries of Central and Eastern Europe, and Croatia should learn from their experience.

Impact of EU Membership on the Health Care Systems of New Members

This study is focused on the health care systems of CEE countries, versus all other member countries, for several reasons: first, countries of Central and Eastern Europe face a different set of health indicators as compared to the older members of Western and Southern Europe. In 2009, the average life expectancy in the Western European Union was 81 years of age for members before 2004, and 75 years of age for Central and Eastern European members who joined in 2004 or 2007, while infant deaths were 3.6 per 1000 and 6 per 1000 live births respectively (WHO, 2013). The differences in life expectancy are primarily due to the burden of diseases such as cardiovascular diseases, and alcohol related diseases and injuries in CEE (Müller-Nordhorn et al., 2008; Rehm et al., 2007). Figure 1 represents male deaths due to cardiovascular disease and diabetes. It is evident that CEE country members of the EU bear the higher burden of disease than the older members.

In fact, alcohol related illnesses have historically been present in some CEE countries such as the North European countries (Estonia, Latvia, Lithuania, Poland) where binge drinking and public intoxication are acceptable as opposed to other countries of CEE where alcohol consumption is nonetheless prevalent (Popova et al., 2007). The infant deaths are likely due to a lower standard of living in some CEECs but also to the prenatal care received within the health care system in the respective groups of countries. Furthermore, Leal et al. have estimated that the burden of cardiovascular (CVD) diseases in the enlarged European Union resulted in

Figure 2: Total Health Expenditures as Percentage of GDP

Source: World Health Organization.

24.4 billion Euros in 2003 (2006). Countries with the largest number of work days lost due to CVD included Poland, Slovakia, the Czech Republic, Sweden and the UK. Hence, the differences in health indicators are also key indicators in social and economic development (Anderson et al., 2002; Chung and Muntaner, 2006) and likely to have far reaching consequences on the burden of diseases and economic development of the Union.

Second, the communist legacy in CEE has left a very different set of circumstances in the health care sector, both with respect to the funding and administration of health care services, as well as the citizens' expectation of the involvement of the State in the provision of health care. Countries of CEE still spend a fraction on health care compared to what other EU member countries spend, which creates a health care system that is challenged by the inability to provide for adequate care of patients, and where consequent secondary underground practices take root through graft and bribery of the medical staff, creating further inequality implications for the populations of these countries. New member countries spend on the average 7 percent of their GDP on health expenditures as compared to the older members' 11 percent (WHO, 2013). For 2011, the total health expenditures in the CEE members were \$1,398 per capita, while those of the older members were nearly three times greater, or \$3,708 per capita (WHO, 2013). Figure 2 shows EU member countries' total health care expenditures for 2011 and indicates that members of former communist countries, for the most part, tend to spend less on their health care sector than other EU members. It is interesting to note that the values in Figure 1 are most-

ly inversely related to the values in Figure 2, so that those countries that spend more on their health care system also have lower male mortality rates.

Salaries of medical staff and other public employees have not kept up with the salaries in the private sector (Davis 2001), which has led to corruption and subpar care (Radin, 2009; Kornai, 2000; Kornai and Eggleston, 2001; Lotspeich, 2003; Alin, Davaki and Mossialos, 2006). This has implications for patients crossing borders in search of better/more expedient care, or movement of the medical staff in search of higher compensation.

As the health care systems of these countries were reformed under the second wave of reforms, and the honeymoon period of the early excitement accompanying the democratic process began to fade, the resulting changes were a patchwork of reforms that did not address the main inefficiencies of the health care sector carried over from the pre-transition period. The result is that the hospitals are overstaffed and are unable to consolidate their budgets, and the system is overly reliant on inpatient care maintaining incentives to fill hospital beds, thus prolonging stay and raising the cost of care. While some provisions within the system have allowed for the privatization of particular sectors (most often pharmacies, dentists, and primary care physicians), the bulk of the care is still administered by the state. The result is often a health care system that is unable to meet the demands of care and is replete with financial problems. Thus, the differences in care between new and old members of the EU are ever so pronounced when one looks at the health care sector, which has implications for the unequal burden of disease for its citizens, and creates pressures for seeking care outside the internal market of individual member states. In addition to understanding the differences and challenges of health care systems that new member states bring along, it is also important to understand what consequences the new member states have had to face so far with respect to health care.

Some of the impacts that the EU membership has had on the health care system of the new countries have been positive in terms of the implementation of new laws concerning patients' rights and transparency, and the implementation of electronic prescription drugs to streamline the process and cut down on cost and potential abuse. For example, the member states signatories to the Convention on Human Rights and Biomedicine have been required to conform their internal laws to the provisions of the Convention. Member states that enacted patients' rights legislation after its ratification included Slovakia and Slovenia (among other older members), Slovakia being the first state to ratify it in 1998 (Nys et al., 2007). The ramifications of the adoption resulted first in a 2001 soft law, followed by a 2004 legislation solidifying patients' rights (Nys et al., 2007). There is also a group of CEE EU members on which the convention had a significant positive impact before they ratified it and during the accession talks: Estonia, Hungary and Lithuania. These are ex-

amples where the aspiration of membership during the accession negotiations into the EU has yielded a health promoting result on new and future member states. In fact, Haughton argues that the most influential period that the EU has on a member state is during the accession negotiations (2007). On the other hand, the ratification of the Convention did not yield significant improvements in the laws passed in the Czech Republic.

Other areas that have been affected include: the mobility of doctors and nurses, within which the establishment of competency evaluation criteria has been established; a common system of regulating medical devices, as well as the already mentioned cross-border patients' rights when seeking medical care, both for tourists and for persons working in other EU member states. The ECJ Directive on the Recognition of Professional Qualifications provides the legal basis for the movement of medical professionals (Mossialos et al., 2010) and it can certainly be seen as a positive impact on the quality of care that patients have access to, in cases where physicians hold a temporary, visiting status to contribute to/direct medical interventions that otherwise would not be available due to their specialization. On the other hand, some argue that the intermittent crossing of borders by health professionals can have an unintended consequence of compromising the continuity of care (Peeters, McKee and Merkur, 2010). However, the issue that is most likely to be pertinent to CEE countries is the flight of physicians out of CEE to member countries where they are compensated better and where they can find a job, which may lead to overpopulation of doctors in the areas to which they move (Avergrinos et al., 2004).

Implications for Croatia

Croatia's accession to the EU on July 1, 2013, is certain to have implications for the health care sector, although we can mostly speculate about its consequences at this stage. It is important to first have an understanding of the situation within the health care system with which Croatia is entering the EU.

Following the initial drop in health indicators during the 1990s as a consequence of the economic downturn (Davis, 2001), Croatia undertook initial reforms in the health care sector in order to address pressing problems afflicting health care, such as continuous deficits, long waiting lines, the behavior of the medical staff, among others (Orešković, 1995; Šarić and Rodwin, 1993). The new objectives and action measures were defined in the 1993 Health Care Act and Health Insurance Act. The three areas of Croatian health care reforms focus were financing, rationing of services, and private incentives in the provision of services (Mastilica and Kušec, 2005).

Budget deficits in the health care sector were one of the first problems addressed in the early 1990s. Financing was centralized through the creation of the

Croatian Institute of Health Insurance, which covers a predetermined range of health care services, specific groups, and a list of prescribed medications (Hebrang, 1994). In order to limit spending, the primary care physicians were contracted by the state insurance fund to provide predetermined services. Cost sharing in the form of co-payments was also introduced for all services and drugs, with the exception of some vulnerable groups such as the elderly, children, etc. Voluntary supplemental health insurance and private health insurance were also introduced as a part of liberalization in health care financing. These cost containment measures implemented over the past thirteen years have had some budgetary success, but have not been received well by the public and by the health care workers (Mastilica and Kušec, 2005). Croatia's overall health care spending was lower than that of EU member states: in 1994, the per capita expenditures were \$231 while the lowest EU member state, Greece, had a spending of \$500 (Mastilica and Chen, 1998), and in 2007 that number had risen to \$1,008, still significantly lower than that of other European Union members. In 2010, Croatia spent 8 percent of its GDP on health care expenditures, compared to the 11 percent EU average (WHO, 2013). The Croatian medical community has observed the negative consequences of this health financing reform, where cost cutting practices have led to lower standards of care, particularly preventive care (Mastilica and Kušec, 2005; Orešković et al., 1997).

The second goal, privatization of services, was achieved primarily through the privatization of small physician practices and pharmacies, or offices rented to private practitioners in public hospitals. While this practice was designed to create more efficiency and responsibility in the system, it also created a two tiered system where the wealthy can buy quality medical services, while those dependent on public health care are subject to long queues, and have difficulties obtaining the needed drugs (Mastilica and Kušec, 2005).

While the reforms achieved some of the desired goals, they also had a less desirable consequence on the welfare of those utilizing the system. Kovačić and Sošić (1998) found that, similarly to other countries in Europe, Croatia was faced with health care sector problems such as control of health expenditures, increases in the quality of care, and the development of different segments within the sector (for example, preventative care, acute care, and others). They also found that there were some specific problems that needed intervention such as a delay in payment and reimbursement to hospitals, vaccination coverage, and hospital services, among others. Hospitals suffered from a shortage of funds, low fixed salaries, unmotivated medical staff, lack of medical equipment, corruption, and long waiting lines (Kovačić and Sošić, 1998; Radin et al., 2011). Given that hospitals are still mostly under the authority of the local (county) governments, they differ in the amount of resources available to them as well.

Since many of the problems facing the Croatian health care system involve both funding as well as the efficiency of the administration and management of health care services, it is unlikely that they will be solved through Croatia's accession into the EU, certainly not directly. In their semi-structured interviews of 49 Croatian individuals including health professionals, patients' associations' representatives and other professionals in the health care industry, Ostojić, Bilas and Franc found that there are both positive and negative expectations of the EU membership to bring to Croatia's health care (2012). As an immediate effect, the respondents expect a better flow of information, growth of medical tourism in Croatia, increased quality, inflow of EU funds, but also increased migration of health care professionals out of Croatia, and increased costs of health care services. The long run effects of EU membership are expected to include the harmonization of Croatian health care with EU standards (EU law), further development of health care tourism, and concentration of health care professionals and institutions in larger metropolitan areas (Ostojić, Bilas and Franc, 2012). This can represent a challenge in health care access and delivery. The increase in cost represents a significant problem, particularly when one considers that currently, the majority of Croatian patients mostly use public health facilities, and that the health care sector is already experiencing funding problems. Thus, while the immediate impact of EU accession on Croatia's health care system may not be significant, some of the anticipated effects are a reflection of Croatia's economic performance and the EU's in general, as well as the performance of the health care sector in particular.

Conclusion

The history of the EU's influence on the health care system of its members points to a slow process which has resulted in greater Europeanization of health care systems, but leaves a lot to be desired when compared to the single market integration and other sectors which have been integrated to a greater degree. However, health and health care have long term implications for the economic and social development and wellbeing of the EU member states, and the need to create a more integrated system has already been recognized. However, the future of a more integrated and coordinated European health care system is uncertain, as the complexity of the sector and its delayed results are not supportive of the formation of critical support groups that will shape a European policy.

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