



New medical trends and policies throughout Central and Eastern Europe

Tendențe și politici actuale în domeniul sănătății în Europa Centrală și de Est

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Abstract

This paper presents some of the main medical trends and some specific policies in the field of human medicine produced in Central and Eastern Europe in the past decades.

Keywords: *family medicine reform, general practitioners' list, capitation payment, gate-keeping principles, expectations of access, choice and convenience*

Rezumat

Articolul prezintă unele dintre principalele tendințe și unele dintre politicile specifice din domeniul medicinei umane care au avut loc în ultimele decenii în Europa Centrală și de Est.

Cuvinte-cheie: *filtrarea pacienților, lista medicilor de familie, plata per-capita, așteptările privind accesibilitatea, alegerea și calitatea serviciilor medicale*

JEL Classification: I11, I18

After the Fall of the Berlin Wall in late 1989, the majority of Central and Eastern European countries, who had been under Soviet influence for decades, were now facing the wind of change along with the challenges of a new European architecture. The health sector was no exception to the rule and, as in many other fields, all the new-born democracies of Central and Eastern Europe have now expressed their wish to totally change the centrally controlled government of Soviet inspiration and design their own health care systems, such as to meet the actual needs of their own citizens. Changes in these countries include:

- introducing market economy mechanisms in health care;
- focusing on population health needs in planning and implementing health care systems;
- seeking to introduce a more general type of care at primary level (i.e. GP /family medicine).

In the meantime, patients' expectations of *access*, *choice* and *convenience* are equally important factors in shaping new models of health care delivery. Likewise, *appropriate timing* for implementation is the key determinant of any health reform's success, as human lives are among the most special materials to work with. The early 1990s was the time when several interest groups in society supported changes in the health care system. Yet, by the end of the decade, the primary-care reforms have changed the initial plans, and elements of a new National Health Service started to emerge, especially:

- general practitioners' lists,
- capitation payment and
- gate-keeping principles.

The Family Medicine Reform in Europe has two main objectives:

- introducing general practice as a specialty in its own rights and
- changing the remuneration system of primary-care doctors.

Its specific tasks are:

- to provide practising primary-care doctors with opportunities for retraining to gain the specialty status of a general practitioner,
- to create a list system for the population to register with a primary-care doctor,
- to introduce a partial gate-keeping system and
- to give the status of the independent contractor to primary-care doctors.

The collapse of the communist regimes and the dissolution of the U.S.S.R. have initiated profound changes by the end of the 1980s. Apart from the radical transformation of the political and economic systems, the social system was also subject to numerous changes. One of the most severely concerned areas was the health sector – particularly health care. Eventually, the major choice for these countries was not between reforming their health sector and maintaining the *status quo*. The actual predicament was whether political change should occur haphazardly or follow a rational reform protocol. The main challenges posed by a successful health reform were:

- the complexity of the policy alternatives to centrally planned health care;
- the lack of a universal reform model;
- the presumable opposition to reforms by certain stakeholders and
- the need to keep health care functioning throughout the lengthy process of reform (Staines, 1999).

Within the Eastern European area, Estonia was among the first countries willing to reform its health-care system. During the first period of independence (1918-1940), this country had a solid tradition of independently practising general practitioners. Later on, under the Soviet regime, the country's health policies were readjusted to fit into the Semashko-type hierarchical, centrally controlled health-care system, where primary medical care is provided extensively by different

specialists in polyclinics (Lember, 1996). Nevertheless, in rural areas, district doctors – educated as general internists – and district general pediatricians acted as the only existent first-line doctors. After Estonia reestablished her independence in 1991, changes in health care and medical education, which had already been set in motion several years earlier, gained pace (Lember, 1996; Maaros, 1994).

The aim of this description and analysis of the Estonian evolution of health policy is to offer a term of comparison with the developments in the Romanian system, assuming that the two countries have numerous historical and political similarities. Our study relies on a framework suggested by W.H.O. (McPake & Kutzin, 1997) and lays special emphasis on the following aspects:

- the contextual key factors driving reform,
- the reform itself and its objectives and
- the process by which the reform was /is implemented.

The main factor confronting all nations in planning their health-care system is the increasing health-care cost. In most cases, the cost is influenced by:

- new technological advances in the diagnosis and treatment of diseases,
- increasing average life expectancy of the population,
- the increasing burden of chronic illness and
- better informed and more demanding populations as consumers of health services.

At the same time, trends towards privatization and the effects of economic globalization are likely to affect the delivery and funding of health care as well (Rivo, 1999).

At the beginning of the 1990s, the situation in Romanian society was favourable for launching changes. Primary care doctors saw an opportunity to establish family medicine as a discipline and specialty in its own right; medical specialists, on the other hand, have always pursued an improvement in the quality of the work of district doctors. In their turn, politicians supported the possibility to better control rising health care costs and, at the same time, were attracted by the novelty of the idea itself. Appropriate timing is known to be the key determinant for successful change: in times of political and social transformation, opportunities for radical adjustment can lead to dramatic changes (World Health Organization, 1996).

In the 1970s and 1980s the gap in health status between Eastern and Western European countries gradually emerged, largely due to rapid increases in premature death in the East and the health-care systems' inability to meet expectations. In the late 1980s to early 1990s, the unique historical opportunity resulting from profound changes in society provided the additional prerequisite for health-care reforms throughout Central and Eastern Europe and things started to improve. Nevertheless, on the part of citizens, major dissatisfactions were expressed, e.g.:

- inequity with respect to access to health services,
- limited freedom of choice,

- occasional low standard of health services,
- discontinuity of care,
- deteriorating health status,
- ignored patients' rights, with the general public's perception of family medicine as an alternative to the Soviet health-care system (Zarkovic *et al.*, 1994).

Thus, patients' expectations concerning *access*, *choice* and *convenience* of care served as primary factors in shaping new models of health-care delivery and supporting the development of more rational and organized medical systems.

The Governments, on the other hand, have supported as best they could the chance to better control rising health-care costs, being at the same time attracted by the new idea of family medicine itself. To overcome the drawbacks of the previous systems, the Ministries of Social Affairs expressed their wider goal of health policy in Central-Eastern Europe, namely to improve the health of the entire population through designing and implementing a primary-care based system which emphasizes health promotion, disease prevention and health protection (World Bank, 1995). The development of family medicine was seen as the next step after the establishment of a mandatory public insurance system in 1992.

In the meantime, doctors who had experienced a strict regulatory system during the Soviet hegemony opine they were given more freedom after the fall of the Iron Curtain. Nonetheless, in many countries the medical community had retained their professional standards along with their major dissatisfactions:

- low income,
- low social prestige,
- inequity with respect to access to public medical facilities and services,
- inadequate education and training (Zarkovic *et al.*, 1994).

Introducing a capitation-based payment for family doctors has been supported as it is believed to lead to:

- a more cost-effective pattern of health care,
- lower administrative costs,
- a more stable financial environment for the provider and
- a visible move towards better access and equity for the population (Staines, 1999; Rivo, 1999).

Several forms of capitation are possible and they differ mainly in scope of coverage:

- payment for the care provided by GPs;
- making GPs responsible for paying for outpatient specialist care to which they refer patients;
- making GPs responsible for paying hospital care;
- additional payments for preventive services.

Because physicians in the previous system were generally unused to being at financial risk, the most modest form of integrated capitation was selected by incorporating an amount of funding to cover defined other expenditure, such as laboratory tests and examinations.

In conclusion, the initial driving forces for the reforms were *primary care doctors and medical educators*, supported strongly by government, the population and third-party payers. Wide interest in the reforms by different stakeholders in the initial phase allowed changes to take place at a relatively high speed. On the other hand, the move to use the private sector, too, in the delivery of health-care services in Central and Eastern European countries reflects a global tendency. Even among countries where both health-care policy and services are public sector-driven, governments are recognizing the potential of private sector competition to improve the efficiency and effectiveness of, and public satisfaction with, health-care provision (Rivo, 1999).

Approximately 40 years ago, D.T. Campbell described reform as 'social experimentation'. Other scholars, too, like Hofstede, Fukuyama, DiMaggio and Dickson, have studied the mechanisms and stages of the shift from a centralized paternalistic health-care system towards a liberal health-insurance based system. One of the striking aspects emphasized by their studies is the strong bond between the cultural profile of a nation and its relationship with its health-care system (Campbell, 1969).

If we have a look at the developments in our country since the 1989 Revolution, we can conclude that Romania has been, all these years, a natural 'experimental laboratory' insofar as the implementation of the health reform is concerned. The major changes have occurred within the larger context of specific political and economic readjustments, imposed by the country's transition to a market economy. The roadmap was not an easy one, it had ups and downs and periods of stagnation, usually in direct correlation with the major electoral events. On the other hand, due to her geographical position and European history, Romania is an excellent candidate for studying and identifying the specific social, cultural and economic features that influence the dynamics of the health sector as such.

Years ago, in an attempt to emphasize its cultural and ethnic diversity, the United States was compared to a 'melting pot'. Yet, this metaphor could be extended to Central and Eastern Europe as well, i.e. to the countries of the ex-Soviet block who had similar tough experiences of transition, such as the Ukraine, the Republic of Moldova, Estonia, Lithuania, Latvia, Bulgaria, ex-Yugoslavia and, more recently, even the young Russian Federation. By comparison, the Visegrad Group's experience – the Czech Republic, Slovakia, Poland and Hungary – has generally been less radical, offering excellent material for contrastive studies and data collection from a relatively small geographical area. It may sound as a truism but the in-depth study of national features (political, economic, ethnic and cultural) could be the best method to anticipate the multiple responses to reform or, more generally, to change, and inspire the decision-making factors positively.

During the decades spent under the communist regime, Romania has developed a paternalist way of action and reaction to change: every decision was supposed to be 'top-bottom', very much like an order that everybody had to accept and execute without asking questions. It is only recently that the young generation of employees (therefore the youngest insurance payers) have raised the question of changes in the health-care system, starting from an extremely important aspect: *active* participation of contributors in the continually changing process of health reform. Practically speaking, the young generation are in favour of a reform that:

- addresses their specific demands and needs of medical care,
- fits their purchasing power and contribution possibilities,
- ensures unlimited access to health-care services, irrespective of social, territorial and ethnic differences.

Truth to say, never in Romania's post-revolutionary history have these demands been taken seriously into account. The discussions we had with young people between 20 and 40, employed either in the public or the private sectors, emphasized people's explicit need to access a health-care system that *functions in real time*.

G.H. Hofstede, a fine observer of the cultural mechanisms that influence organizational behaviour, has described culture as 'a collective software of the mind that effects the distinction between social groups or communities' (Hofstede, 1997). He insists upon the ways in which religious and cultural allegiance can establish strong bonds among the individuals of a given cultural 'region'. Unfortunately, throughout the second half of the XXth century, these tendencies towards regional and /or ethnic differentiation have been stronger than ever, taking on various shapes, from 'simple' demands for secession, to severe armed conflicts and even genocide (e.g. ex-Yugoslavia, ex-Soviet Union etc.). As a direct consequence thereof, implementing a health-care reform in the newly resulted countries has been even more difficult than in the non-involved countries.

Judging from this perspective, Romania has been a 'non-involved' country, though, over the years, she has constantly had to face certain ethnic, cultural and social differences herself. Some of them have turned into extremely violent episodes (e.g. the multiple Mineriads, the delicate relationship with the Republic of Moldova, local ethnic conflicts, riots and social turmoil caused by unemployment, poverty, urban-rural discrimination etc.). Nevertheless, the physical length and intensity of these conflicts was far smaller than in ex-Yugoslavia and the ex-Soviet Union, though, in time, the moral drawbacks may prove just as harmful to the country's future as the open conflicts in the real war theatres.

The common denominator of Romanians' current dissatisfaction appears to be a strong resistance to reform, which is directly proportional to the lack of consistence, vision and transparency that has accompanied, so far, the plans drafted on paper by various politicians. People are reluctant to change (especially in mono-industrial areas like the Jiu Valley, Hunedoara, Galați, Calărași) because, poor as they already are, with an unconvincing and chronically ineffective political and

managerial class in the background, they are afraid of becoming even poorer in the future. Many of them feel betrayed and abandoned in a bureaucratic chaos, which has eroded their confidence both in the policy-makers and in the medical professionals.

At a closer look, this situation originates in a strong and lengthy inability of older politicians and managers to take into account the *human component*. It is only now, in many years of trial-and-error pursuits, that control is gradually taken over by a new generation of leaders, educated in the West and exposed to Western values, who are deemed to be capable of redesigning things outside the vicious circle of the spectral 'realist-socialism' philosophy and of bringing Romania where she rightfully belongs. The same process seems to have been easier for the Central European countries, due to their greater proximity to the West – though, they, too, had to overcome their own problems and are still struggling for improvement. Apart from this, the global economic recession had its final say everywhere, making things even harder for everybody across the world.

An important point made by Hofstede in his studies is that traditional cultural values and other forms of traditional-isms are extremely resistant to change (Hofstede, 1997). Among the examples he enumerates are the ex-Soviet Union countries who, after 45 years of Soviet hegemony, are still very slow with reforms and progresses towards liberalism and, therefore, still far from the countries with a rich democratic tradition behind.

In his turn, P. DiMaggio has emphasized the strong influence exerted by the different cultural levels of a given society – e.g. national, social and organizational patterns – over its economic 'behaviour' and, subsequently, over the amount of production and investment in key sectors such as health care and medical assistance (DiMaggio, 1994). To demonstrate his point, he has likened the behaviour of workers in two different countries, with very different cultures but with comparably strong industries – the United States and Japan. He insists on the fact that, in Japan, the frequency of strikes, absenteeism, medical leaves and (motivated or fictive) malpractice trials against the medical personnel is much lower than in the United States. In his opinion, this is a practical example of 'constructive collectivism' on the part of the Japanese working class, with obvious positive implications over the health-care system of a country in which investment in medical technology is huge and efficiency in terms of diagnosis and therapy are world famous. We may also note that, in Japan, the number of public and private health insurers is approximately equal.

Finally yet importantly, F. Fukuyama opines that the ethical-moral and social-customary development of a people /nation has a crucial influence over its economic development, though this particular feature may prove to be either a 'blessing' or a 'curse' (Fukuyama, 1995). By this antithesis, the author tries to account for the major economic differences between Western and Eastern Europe that frequently exert a negative influence on the health-care system. His assumption is that, though a change in the cultural attitude may be costless on the

one hand, the same cultural attitude may become extremely expensive, on the other, depending on the 'prestige' attached to it at one moment or another, in one place or another. This is especially the case of the health-care sector, which, highly unpredictable as it is by definition, cannot be regulated or controlled by mere economical devices.

In conclusion, Romania is in the 'comfortable' position of not having to reinvent the wheel, but of having to learn how to keep it spinning – which, in the long run and given the global economic crisis, may prove to be even more difficult. Only time will tell.

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